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No 11-1285

Title:

US Airways, Inc., in its Capacity as Fiduciary and Plan Administrator of the US

Airways, Inc. Employee Benefits Plan, Petitioner

V.

James E. McCutchen, et al.

Docketed:

April 25, 2012

Linked with 11A879

Lower Ct:

United States Court of Appeals for the Third Circuit

Case Nos.:

(10-3836)

Decision Date:

November 16, 2011

Rehearing Denied: January 4, 2012

Questions Presented

~~Date~~~ ~~~~Proceedings and Orders~~~~~~~~~~

Mar 14 2012 Application (11A879) to extend the time to file a petition for a writ of certiorari from April 3, 2012 to May 23, 2012, submitted to Justice Alito.

Mar 16 2012 Response to application from respondents James E. McCutchen, et al. filed.

Mar 17 2012 Application (11A879) granted by Justice Alito extending the time to file until May 3, 2012.

Apr 25 2012 Petition for a writ of certiorari filed. (Response due May 25, 2012)

May 8 2012 Order extending time to file response to petition to and including June 5, 2012.

May 25 2012 Brief amici curiae of National Association of Subrogation Professionals, et al. filed.

Jun 5 2012 DISTRIBUTED for Conference of June 21, 2012.

Jun 5 2012 Brief of respondents James E. McCutchen, et al. in opposition filed. (Distributed)

Jun 8 2012 Reply of petitioner US Airways, Inc., in its Capacity as Fiduciary and Plan Administrator of the US Airways, Inc. Employee Benefits Plan filed. (Distributed)

Jun 12 2012 Letter of June 7, 2012, from counsel for respondents received. (Distributed)

Jun 20 2012 Letter of June 20, 2012, from counsel for petitioner received. (Distributed)

Jun 20 2012 Letter of June 20, 2012, from counsel for respondents received. (Distributed)

Jun 25 2012 Petition GRANTED.

Jul 26 2012 The time to file the joint appendix and petitioner's brief on the merits is extended to and including August 29, 2012.

Jul 26 2012 The time to file respondent's brief on the merits is extended to and including October 18, 2012.

Aug 15 2012 Consent to the filing of amicus curiae briefs, in support of either party or of neither party, received from counsel for the petitioner, and counsel for the respondents.

Aug 29 2012 Joint appendix filed.

Aug 29 2012 Brief of petitioner US Airways, Inc., in its Capacity as Fiduciary and Plan Administrator of the US Airways. Inc. Employee Benefits Plan filed. Sep 5 2012 Brief amicus curiae of the United States in support of neither party filed. Sep 5 2012 Brief amici curiae of Blue Cross Blue Shield Association, et al. filed. Sep 5 2012 Brief amicus curiae of National Coordinating Committee for Multiemployer Plans filed. Sep 5 2012 Brief amici curiae of National Association of Subrogation Professionals, et al. filed. Sep 5 2012 Brief amicus curiae of Central States. Southeast and Southwest Areas Health and Welfare Fund filed. Sep 5 2012 Brief amici curiae of Chamber of Commerce of the United States of America, et al. filed. Sep 14 2012 SET FOR ARGUMENT ON Tuesday, November 27, 2012. Sep 14 2012 CIRCULATED Oct 4 2012 Record received from the U.S.C.A. for the Third Circuit is electronic. And the record from the U.S.D.C. for Western District of Pennsylvania is included in this record. Oct 18 2012 Brief of respondents James E. McCutchen, et al. filed. (Distributed) Oct 18 2012 Brief amici curiae of Pennsylvania Association for Justice filed. (Distributed) Oct 25 2012 Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed. Oct 25 2012 Brief amici curiae of United Policyholders, et al. filed. (Distributed) Oct 25 2012 Brief amicus curiae of Consumer Watchdog filed. (Distributed) Oct 25 2012 Brief amicus curiae of American Association for Justice filed. (Distributed) Oct 25 2012 Brief amici curiae of AARP, et al. filed. (Distributed) Oct 25 2012 Brief amici curiae of Law Professors filed. (Distributed) Oct 25 2012 Brief amicus curiae of Michigan Association for Justice filed. (Distributed) Nov 13 2012 Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED. Nov 13 2012 Reply of petitioner US Airways, Inc., in its Capacity as Fiduciary and Plan Administrator of the US Airways, Inc. Employee Benefits Plan filed. (Distributed) Nov 19 2012 Letter proposing a lodging of the U.S. Airways, Inc. Health Benefit Plan ("Plan") received from counsel for respondents. (Distributed) Nov 26 2012 LODGING received from counsel for the respondents. (Distributed) Nov 27 2012 Argued, For petitioner: Neal Kumar Katyal, Washington, D. C. For United States, as amicus curiae: Joseph R. Palmore, Assistant to the Solicitor General, Department of Justice, Washington, D. C. For respondents: Matthew W. H. Wessler, Washington, D. C.

PETITION FOR WRIT OF CERTIORARI

11-1285

Supreme Court, U.S. F1LED

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IN THE

Supreme Court of the United States

U.S. AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN,

Petitioner,

V.

JAMES MCCUTCHEN and ROSEN, LOUIK & PERRY, P.C., Respondents.

> On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Employee benefit plans often cover a participant's medical bills in the event of injury but require that, if the participant obtains compensation from a third party for that injury, he or she reimburse the plan in full. Under Section 502(a)(3) of the Employee Retirement Income Security Act ("ERISA"), plans may enforce these reimbursement provisions in court by seeking "appropriate equitable relief" to enforce "the terms of the plan." 29 U.S.C. § 1132(a)(3).

Twice in recent years this Court has resolved disputes about how Section 502(a)(3) works in reimbursement actions. In the more recent case, Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356 (2006), the Court expressly reserved a third question about the provision. The Third Circuit, in its words, has now "squarely" answered "the question that Sereboff left open," Pet. App. 9a, and has done so in a way that, as it acknowledged, splits the circuits.

The question presented is: Whether the Third Circuit correctly held—in conflict with the Fifth, Seventh, Eighth, Eleventh, and D.C. Circuits—that ERISA Section 502(a)(3) authorizes courts to use equitable principles to rewrite contractual language and refuse to order participants to reimburse their plan for benefits paid, even where the plan's terms give it an absolute right to full reimbursement.

PARTIES TO THE PROCEEDINGS

The following were parties to the proceedings in the U.S. Court of Appeals for the Third Circuit:

- 1. US Airways, Inc., the petitioner on review, was plaintiff-appellee below.
- 2. James McCutchen and Rosen, Louik & Perry, P.C., respondents on review, were defendants appellants below.

RULE 29.6 DISCLOSURE STATEMENT

Petitioner US Airways, Inc. is a wholly owned subsidiary of US Airways Group, Inc., which owns 10 percent or more of US Airways, Inc. stock. US Airways Group, Inc. is a publicly-traded company.

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Supreme Court of the United States

No. 11-

U.S. AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN.

Petitioner.

V.

JAMES MCCUTCHEN and ROSEN, LOUIK & PERRY, P.C., Respondents.

> On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

PETITION FOR A WRIT OF CERTIORARI

U.S. Airways, Inc. respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit.

OPINIONS BELOW

The District Court's order is not reported, but is available at 2010 WL 3420951 (Pet. App. 18a). The Third Circuit's decision is reported at 663 F.3d 671 (Pet. App. 1a).

JURISDICTION

The Third Circuit entered judgment on November 16, 2011 and denied rehearing on January 4, 2012. Pet. App. 38a, 41a. On March 17, 2012, Justice Alito extended the time to file this petition to May 3, 2012. This Court's jurisdiction rests on 28 U.S.C. § 1254(1).

STATUTE INVOLVED

Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), provides in relevant part:

A civil action may be brought * * * by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan[.]

INTRODUCTION

The Employee Retirement Income Security Act ("ERISA") is a legislative balancing act: Congress chose to regulate employee benefit plans, but at the same time it sought to avoid discouraging employers from offering benefits in the first place. Congress thus set out in ERISA to "induc[e] employers to offer benefits by assuring a predictable set of liabilities." Rush Prudential HMO Inc. v. Moran, 536 U.S. 355, 379 (2002). To accomplish that goal, ERISA relies on a "straightforward rule" of "hewing to" the contractual "plan documents" in which plans set forth their terms. Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan, 555 U.S. 285, 300 (2009). ERISA "is built around reliance on the face of [those] written plan documents," id. (citation omitted), and its "repeatedly emphasized purpose [is] to protect contractually defined benefits." Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985).

The Third Circuit's decision below eviscerates that statutory purpose—and, in so doing, precipitates a circuit split on a question this Court expressly "left open" in an earlier case. Pet. App. 9a. The issue

involves reimbursement provisions of employee benefit plans. Those provisions typically require participants to reimburse the plan for medical payments made on their behalf if they end up recovering from third parties. In Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356 (2006), this Court held that plans can enforce reimbursement provisions under ERISA Section 502(a)(3)—which authorizes plans to seek "appropriate equitable relief" to enforce plan terms, 29 U.S.C. § 1132(a)(3)—because the provisions amount to an equitable lien by agreement. But Sereboff reserved for another day the separate question whether plan participants can rely on equitable defenses to defeat an unambiguous reimbursement provision. 547 U.S. at 368 n.2.

Five courts of appeals have answered that question in the negative, holding that clearly worded reimbursement provisions should be enforced as written. The Third Circuit has now expressly broken with those courts. In the decision below, it wrote that it "disagree[d]" with their holdings. Pet. App. 14a. It instead held that Section 502(a)(3) authorizes courts to rewrite unambiguous plan language—and thus eliminate a plan's right to reimbursement—if the court feels that enforcing the plan's terms is not "appropriate" in a given case.

That holding warrants review. It splits the circuits. It flies in the face of this Court's cases and ERISA's expressed intent. It endangers employer-provided health plans—and the tens of millions of American workers who participate in those plans—by cutting into reimbursement revenues on which they rely to remain financially viable. And it creates confusion on a recurring, and oft-litigated, issue: The federal courts decide dozens of ERISA reim-

bursement cases each year, and this Court has granted *certiorari* no fewer than four times in an effort to establish national uniformity with respect to ERISA remedies under Section 502(a)(3).

This case, in short, is a prime candidate for certiorari review. The Court should grant the writ and reverse the decision below.

STATEMENT

A. ERISA and Section 502(a)(3)

1. Congress enacted ERISA to provide a uniform regulatory regime over employee benefit plans. See 29 U.S.C. § 1001(b). The statute "places the regulation of private sector employee benefit plans (including health benefits) primarily under federal jurisdiction for about 177 million people." Congressional Res. Serv., ERISA Regulation of Health Plans: Fact Sheet 1 (Oct. 3, 2007). And "[w]hile ERISA does not require an employer to offer health benefits, it does mandate compliance if such benefits are offered." Id.

Benefit plans set forth their terms in written plan documents, which constitute "contracts." CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1879 (2011). Section 502 of ERISA, codified at 29 U.S.C. § 1132, regulates how parties to these contracts can enforce them. Section 502(a)(1) authorizes plan participants to file civil actions seeking the usual panoply of remedies at law. For plans themselves, Section 502(a)(3) provides that a plan administrator seeking to enforce the plan's terms against a participant must file a civil action and seek an injunction or "other appropriate equitable relief *** to enforce

¹ Available at http://congressionalresearch.com/RS20315/document.php?study=ERISA+Regulation+of+Health+Plans+Fact+Sheet.

any provisions of this subchapter or the terms of the plan[.]" Id. § 1132(a)(3)(B).

This Court repeatedly has "had occasion to clarify" the remedies available under the "other appropriate equitable relief' language of Section 502(a)(3). Sereboff, 547 U.S. at 361. In Mertens v. Hewitt Associates, 508 U.S. 248 (1993), the Court construed the provision to authorize only "those categories of relief that were typically available in equity." Id. at 255-256 (emphasis deleted). But in two cases that followed-both of which involved reimbursement actions similar to the one here—the Court made clear that while the relief sought must be equitable. that does not prevent plans from enforcing their terms and collecting reimbursement. In Great-West Life & Annuity Insurance Co. v. Knudson, 534 U.S. 204 (2002), the Court held that plans may seek restitution for a participant's failure to reimburse so long as the reimbursement claim is equitable, not Id. at 213. And in Sereboff, a unanimous Court explained that reimbursement provisions create an "equitable lien by agreement" that the plan may enforce under Section 502(a)(3). 547 U.S. at 364-365. The Court ordered the defendant plan participants to reimburse their plan some \$74,000 the amount the plan had paid out to cover their medical expenses. Id. at 360.

The participants in Sereboff separately argued that even if the relief the plan sought was "equitable," it was not "appropriate" under Section 502(a)(3)'s "other appropriate equitable relief" provision. Id. at 368 n.2. That was so, they argued, because the word "appropriate" authorizes courts to consider equitable defenses such as the "make-whole doctrine"—which requires that an insured party be fully compensated

for all injuries before a subrogee can obtain any reimbursement—and use those defenses to effectively override the plan's contractual reimbursement provision. *Id.* This Court identified the argument but reserved it for another day: "[F]rom our examination of the record it does not appear that the Sereboffs raised this distinct assertion below. We decline to consider it for the first time here." *Id.*

2. Both before and after Sereboff, courts of appeals have confronted that reserved question-and until the decision below in this case, all had answered it in the negative, holding that unambiguous reimbursement provisions should be enforced as written. In Administrative Committee of Wal-Mart Stores v. Shank, 500 F.3d 834 (8th Cir. 2007), cert. denied, 552 U.S. 1275 (2008), for example, the plan included a reimbursement provision similar to the one at issue here. Id. at 835. Despite the provision's unambiguous terms, the plan participants argued that full reimbursement was not "appropriate" under Section 502(a)(3), and they asked the court to apply one of two equitable defenses-either the "make whole" doctrine or a pro rata share requirement-to override the reimbursement provision. Id. at 837.

The Eighth Circuit declined to read Section 502(a)(3) to import equitable defenses into ERISA or to authorize them as a matter of federal common law. It explained that "[r]eimbursement and subrogation provisions are crucial to the financial viability of self-funded ERISA plans," and that plans must "preserve assets to satisfy future, as well as present, claims.'" Id. at 838 (quoting Varity Corp. v. Howe, 516 U.S. 489, 514 (1996)). And it recognized that "[a]mong the primary purposes of ERISA is to ensure the integrity of written plans." Id. It accordingly

refused to use Section 502(a)(3) "to alter the express terms of a written plan." Id. at 838. The panel concluded: "Nothing in the statute suggests Congress intended that section 502(a)(3)'s limitation of the [plan's] recovery to 'appropriate equitable relief would upset [the parties'] contractually defined expectations." Id. at 839.

Other circuits have reached the same conclusion, holding that Section 502(a)(3) does not authorize courts to rewrite reimbursement provisions and that to do so would "frustrate, rather than effectuate, ERISA's 'repeatedly emphasized purpose to protect contractually defined benefits.' " Zurich Am. Ins. Co. v. O'Hara, 604 F.3d 1232, 1237 (11th Cir. 2010), cert. denied, 131 S. Ct. 943 (2011) (quoting Russell, 473 U.S. at 148). Accord Moore v. CapitalCare, Inc., 461 F.3d 1, 9 (D.C. Cir. 2006); Bombardier Areospace Empl. Welfare Benefits Plan v. Ferrer, Poirot, & Wansbrough, 354 F.3d 348, 357 (5th Cir. 2003), cert. denied, 541 U.S. 1072 (2004); Administrative Comm. of Wal-Mart Stores v. Varco, 338 F.3d 680 (7th Cir. 2003), cert. denied, 542 U.S. 945 (2004).

B. The Decision Below

1. The decision below breaks with that previously uniform line of circuit court decisions. The case "stems from a tragic car accident in which a young driver lost control of her car, crossed the median of the road, and struck a car driven by" respondent James McCutchen. Pet. App. 3a. McCutchen was seriously injured in the January 2007 accident—he underwent a hip replacement and physical therapy—and those injuries, combined with previous chronic ailments, left him "functionally disabled." Id.

McCutchen was covered by a health benefit plan (the "Plan") administered and self-financed by his employer, US Airways. After the accident, the Plan "paid medical expenses in the amount of \$66,866 on his behalf." Id. Meanwhile, McCutchen sought to recover from the driver who had injured him. He eventually settled with that driver for \$10,000. Id. "[W]ith his lawyers' assistance, he and his wife received another \$100,000 in under-insured motorist coverage for a total third-party recovery of \$110,000." His attorneys took their fees off the top of that recovery. After those fees and expenses, McCutchen's "net recovery was less than \$66,000." Id.

2. The Plan contains a reimbursement provision effectively identical to the ones the courts of appeals addressed in *Shank* and the other cases just discussed. The provision is included in the Summary Plan Description, in a paragraph entitled "Subrogation and Right of Reimbursement." It provides:

The purpose of the Plan is to provide coverage for qualified expenses that are not covered by a third party. If the Plan pays benefits for any claim you incur as the result of negligence, willful misconduct, or other actions of a third party, the Plan will be subrogated to all your rights of recovery. You will be required to reimburse the Plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, your own insurance company[.] *** In addition you *** may not negotiate any agreements with a third party that would undermine the subrogation rights of the Plan. [Pet. App. 4a-5a (emphasis added).]

Invoking that provision, US Airways in June 2007 placed McCutchen and his counsel on notice of a potential lien against any recovery they might ob-

tain. Pet. App. 19a-20a. McCutchen and his counsel nonetheless settled his claims in 2008 and failed to inform US Airways about the settlements. See id.

US Airways eventually found out about the settlements anyway. Applying the reimbursement provision by its terms, US Airways asked McCutchen to reimburse the Plan "for the entire \$66,866 that it had paid for [his] medical bills." Pet. App. 3a. McCutchen refused. His attorneys, meanwhile, placed \$41,500 of the \$110,000 recovery in a trust account, "reasoning that any lien found to be valid would have to be reduced by a proportional amount of legal costs." Pet. App. 4a.

US Airways, acting in its capacity as plan administrator, then filed suit, seeking "appropriate equitable relief" under Section 502(a)(3) "in the form of a constructive trust or an equitable lien on the \$41,500 held in trust and the remaining \$25,366 personally from McCutchen." Pet. App. 4a. US Airways argued that the reimbursement provision plainly entitled the Plan to full reimbursement. McCutchen, in response, raised the panoply of arguments that plan participants had raised in cases like Shank and O'Hara. He argued that any reimbursement should be reduced, or eliminated entirely, under the makewhole and pro-rata-share doctrines. Pet. App. 5a. And he argued that "US Airways, which made no contribution to his attorneys' fees and expenses, would be unjustly enriched if it were now permitted to recover from him without any allowance for those He asked the court to apply those costs[.]" Id.equitable doctrines under Section 502(a)(3) to override the Plan's reimbursement rights. Pet. App. 5a.

3. Recognizing that the reimbursement provision's "any monies recovered" language plainly entitled the

Plan to full reimbursement, the District Court "rejected McCutchen's arguments and granted summary judgment to US Airways." Id.

The Third Circuit reversed. As the panel saw it, "it would be strange for Congress to have intended that relief under Section 502(a)(3) be limited to traditional equitable categories," as described in *Knudson* and *Sereboff*, "but not limited by other equitable doctrines and defenses that were traditionally applicable to those categories." Pet. App. 10a. It thus held that "Congress intended to limit the equitable relief available under Section 502(a)(3) through the application of equitable defenses." Pet. App. 11a.

The panel attempted to find support for that approach in this Court's recent decision in CIGNA Corp. v. Amara, which held that courts have "[t]he power to reform contracts" in ERISA cases "to prevent fraud." 131 S. Ct. at 1879 (emphasis added). The panel acknowledged that there was not even the slightest hint of fraud or dishonesty in this case. Pet. App. 15a. It nonetheless read CIGNA to stand broadly for the proposition that "the importance of the written benefit plan is not inviolable, but is subject—based upon equitable doctrines and principles-to modification and, indeed, even equitable reformation under Section 502(a)(3)." Id. It further concluded that, in equity, "contractual language [i]s not as sacrosanct as it is normally considered to be when applying breach of contract principles at common law." Id.

The panel acknowledged that its holding created a split with the Fifth, Seventh, Eighth, and Eleventh Circuit cases discussed above. The panel cited all of those cases, quoted *Shank* and *O'Hara*, and squarely rejected their analysis. It wrote: "We disagree with

those circuits that have held that it would be pioneering federal common law to apply equitable limitations on an equitable claim. *** By categorically excluding the equitable limitations that Section 502(a)(3)'s reference to equitable remedies necessarily contains, the Shank and O'Hara courts depart from the text of ERISA." Pet. App. 14a-15a. The court remanded the case for a determination of what—if any—reimbursement McCutchen should be required to provide.

US Airways sought rehearing. It was denied. Pet. App. 41a. This petition followed.

REASONS FOR GRANTING THE PETITION

This case meets every criterion for certiorari review. The decision below creates a "direct conflict" among the circuits. R. Stern et al., Supreme Court Practice 242 (9th ed. 2007) ("Stern & Gressman"). The conflict is over an oft-litigated statutory provision that this Court has seen fit to construe on multiple occasions—the last time expressly reserving the question now presented here. The Third Circuit's approach conflicts with this Court's decisions. And the subject matter is of significant importance to millions of ERISA plans and plan participants across the nation: Plans seek to recoup billions of dollars a year through reimbursement, and they rely on reimbursement provisions to remain financially viable in a healthcare market characterized by spiraling costs. The approach adopted below would cut into those recoveries, making employersponsored coverage less affordable and potentially provoking some employers to drop their benefit plans altogether. Just as important, the Third Circuit's approach renders it impossible for plans to rely on their reimbursement rights; after all, any given judge could choose to erase them from the contract. That is precisely the opposite of what Congress wanted when it enacted a statute designed to "induce[]] employers to offer benefits by assuring a predictable set of liabilities." Rush Prudential, 536 U.S. at 379. The petition should be granted.

I. THE QUESTION PRESENTED HAS DIVIDED THE CIRCUITS.

There is no question that the decision on review created a circuit split: The Third Circuit says courts can use equitable principles to override contractual reimbursement provisions under Section 502(a)(3). Five other circuits say they cannot. As in Sereboff, the Court should "grant[] certiorari to resolve the disagreement." 547 U.S. at 361.

1. Prior to the decision below, every circuit to consider the question enforced unambiguous benefit-plan reimbursement provisions under Section 502(a)(3), observing that ERISA's primary purpose is "to protect the integrity of [ERISA] plans and the expectations of their participants and beneficiaries." O'Hara, 604 F.3d at 1237 n.3 (citation omitted).

The Eleventh Circuit. The Eleventh Circuit in O'Hara sustained a claim identical to US Airways' claim here—that is, a claim for reimbursement corresponding to medical benefits paid—by enforcing the reimbursement provision as written. The plan participant argued, as McCutchen did below, that full reimbursement was not "appropriate" under Section 502(a)(3). 604 F.3d at 1236. He argued, also as here, that such reimbursement would "unduly punish[] him" and "unjustly enrich[]" the plan. Id. at 1237. And he argued, also as here, that the court should apply equitable principles through Section 502(a)(3) to override the plan's reimbursement

provision. Id. The Eleventh Circuit rejected these arguments across the board. It found that refusing to enforce the reimbursement provision as written would "frustrate, rather than effectuate, ERISA's 'repeatedly emphasized purpose to protect contractually defined benefits.' " Id. (quoting Russell, 473 U.S. at 148). As the court of appeals explained, enforcing reimbursement provisions as written is critical to plan solvency—and thus benefits all plan participants. Id. at 1238.

The Eighth Circuit. Likewise, in Shank, the Eighth Circuit rejected a plan participant's argument that full reimbursement was not "appropriate" under Section 502(a)(3) and that the court should apply make whole and pro rata equitable theories to rewrite the contract. 500 F.3d at 837. The court declared itself "not persuaded that [the plan's] full recovery according to the terms of the plan is not 'appropriate' relief within the meaning of ERISA." Id. It wrote that because "ensurling the integrity of written plans" was "[a]mong the primary purposes of ERISA," it would not "alter the express terms of a written plan." Id. at 838. "This is especially true in the context of section 502(a)(3)," it observed, because that provision "'does not, after all, authorize appropriate equitable relief at large, but only appropriate equitable relief for the purpose of * * * enforc[ing] any provisions of ERISA or an ERISA plan." Id. (quoting Mertens, 508 U.S. at 253).

The D.C. Circuit. The D.C. Circuit reached the same conclusion in *Moore*. The plan participants in *Moore*, like those in *Shank* and *O'Hara*, relied on the term "appropriate" in Section 502(a)(3), arguing that it contemplated equitable defenses to the contractual reimbursement obligation. 461 F.3d at 8-9. The

plan argued that the Moores had waived that argument, but the court brushed the waiver issue aside, holding that the participants' argument failed even if it was preserved. *Id.* at 8 n.9. The court wrote: "[T]he ERISA plan unambiguously establishes a plan priority to any third party recovery the beneficiary obtains ***. We believe that this language plainly entitles [the plan] to recover from the Moores all amounts the ERISA plan has paid[.]" *Id.* at 10.

The Fifth & Seventh Circuits. The Fifth and Seventh Circuits likewise rejected attempts to rewrite reimbursement provisions on equitable theories, both in opinions issued before this Court decided Sereboff. 2 In Bombardier, the Fifth Circuit rejected a plan participant's argument that amounts designated as attorneys' fees were outside the scope of the plan's reimbursement rights: "This assertion ignores [the participant's] pre-existing contractual reimbursement obligation to the Plan ***. This preexisting reimbursement obligation precluded [him] from contracting away to the law firm that which he did not own himself, namely, the right to all or any portion of the \$13.643.63 that rightfully belonged to the plan." 354 F.3d at 357. Likewise, in Varco, the Seventh Circuit refused to reduce the plan's contractual reimbursement to account for attorney's fees the plan participant had incurred. 338 F.3d at 691. The court rejected the participant's argument that it

² Sereboff identified Bombardier and Varco as two decisions on one side of the circuit split over whether a plan fiduciary could seek reimbursement from a third-party settlement under Section 502(a)(3). 547 U.S. at 361 n.1. Because this Court resolved the split in favor of Bombardier and Varco, the reasoning of those cases was left intact. And because both cases had addressed the issue left open in Sereboff and presented in this case, they form part of the circuit split here, too.

would be "unjust enrichment" for the plan to obtain reimbursement without contributing to the attorney's fees. Because the plan language was clear and unambiguous, the court wrote, "any so-called enrichment is not unjust." *Id.* at 692.

2. The Third Circuit, however, "disagreed" with the analysis of its sister circuits to have addressed the issue. Pet. App. 14a. According to the Third Circuit, O'Hara, Shank, Bombardier, and Varco all impermissibly "depart[ed] from the text of ERISA," Pet. App. 15a, so the Third Circuit departed from them. Thus, after the Third Circuit's decision, the same case, with the same reimbursement provision, will come out differently in the Fifth, Seventh, Eighth, Eleventh, and D.C. Circuits than it would in the Third Circuit. That is "a real or 'intolerable' conflict on the same matter of law or fact"—in other words, an outcome-determinative circuit split—of the sort this Court regularly grants certiorari to resolve. Stern & Gressman 241.

The lower courts, too, appear to be recognizing the new divide between the circuits in the few months since the Third Circuit's decision issued. In Schwade v. Total Plastics, Inc., __ F. Supp. 2d __, 2011 WL 5459649 (M.D. Fla. Nov. 10, 2011), the District Court wrote that the Third Circuit's decision created a "circuit split" and that the decision is "irreconcilable" with the Eleventh Circuit's decision in O'Hara. Id. at *16. Just so. This Court should step in to unify the law, as it did in Knudson when one court of appeals split with three other circuits on the meaning of Section 502(a)(3). See Pet. for Certiorari, Knudson, 534 U.S. 204 (No. 99-1789), 2000 WL 34014494, at *10.

II. THE DECISION BELOW CONFLICTS WITH THIS COURTS CASES AND WITH FUNDAMENTAL PRINCIPLES OF ERISA.

This case separately warrants review because it involves an "important federal question," and the Third Circuit's resolution of that question "conflicts with relevant decisions of this Court." S. Ct. R. 10(c).

1. ERISA's statutory scheme is "built around reliance on the face of written plan documents." Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 83 (1995). The court below rejected that fundamental principle when it nullified the Plan provision requiring participants "to reimburse the Plan for amounts paid for claims out of any monies recovered from a third party." Pet. App. 26a. The effect of the Third Circuit's decision is to read into every ERISA plan an implicit limitation on the plan's rights: Reimbursement is permitted only where, in the court's view, it is justified under the facts of a particular case.

That approach conflicts with this Court's ERISA precedents in two key ways. First, it ignores the teaching that Section 502(a)(3) "does not *** authorize 'appropriate equitable relief at large, but only 'appropriate equitable relief for the purpose of 'redress[ing any] violations or *** enforc[ing] any provisions' of ERISA or an ERISA plan." Mertens, 508 U.S. at 253 (citation omitted; alteration and second ellipsis in original). The Third Circuit turned that principle on its head when it concluded that the right to seek equitable relief to enforce a plan somehow "expressly tempered" the importance of the terms of the plan. Pet. App. 16a. That does not follow; Congress empowered plans to seek equitable relief to enforce their written terms, not terms cho-

sen at random by a judge. Construing Section 502(a)(3) as the Third Circuit did here contradicts what this Court has described as ERISA's "repeatedly emphasized purpose": "to protect contractually defined benefits." Russell, 473 U.S. at 148.

Second, the decision below is wholly inconsistent with this Court's instruction that, when "fashioning 'appropriate' equitable relief' under 502(a)(3), a court should "keep in mind the special nature and purpose of employee benefit plans." Varity Corp., 516 U.S. at 515 (quotation marks & citation omitted). When US Airways "raise[d] a practical concern that the application of equitable principles will increase plan costs and premiums," the Third Circuit dismissed the concern out of hand, concluding that it "does not address the statutory language and is, in any event, unsubstantiated by the circumstances of this case." Pet. App. 16a. That was a shallow brushoff. The "statutory language" of Section 502(a)(3) does not sit in a vacuum; it is part of a highly complex statutory scheme. relevant point of that scheme, as this Court has explained time and again, is that ERISA plans must be able to control their liabilities so that they can afford to provide benefits to all employees, not just those before the court in a particular case.

"ERISA does not create any substantive entitlement to employer provided health benefits or any other kind of welfare benefits." Curtiss Wright Corp., 514 U.S. at 78. Instead, as already explained, the statute "induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." Conkright v. Frommert,

130 S. Ct. 1640, 1649 (2010) (quoting Rush Prudential, 536 U.S. at 379). And it counsels "[d]eference to plan administrators, who have a duty to all beneficiaries to preserve limited plan assets." Id. at 1650. The Third Circuit's decision undercuts all of these goals. It throws predictability out the window for ERISA plans. And it causes contractual benefits to run in only one direction: The participant is guaranteed the certainty of immediate reimbursement for medical expenses, but the plan is denied the same guarantee of reimbursement from third-party recovery. After the Third Circuit's decision, subrogation and reimbursement depend on a court's approval of the propriety of that relief, or perhaps just a portion of it, on a case by case basis, long after a plan has paid the money it is contractually obligated to com-This is antithetical to "a uniform regime of ultimate remedial orders and awards." Id. at 1649.

2. The court purported to find authority for its approach from this Court's decision in CIGNA, 131 S. But it could do so only by distorting CIGNA's reasoning. In CIGNA, this Court held that reformation of a benefit plan may be an appropriate remedy under Section 502(a)(3) in certain cases because "the power to reform contracts * * * is a traditional power of an equity court *** used to prevent fraud." 131 S. Ct. at 1879 (emphasis added). The CIGNA Court thus grounded reformation in its historical context and recognized its potential availability in one type of case: where a contracting party committed fraud or misrepresentation. See id. The Third Circuit ignored this critical contextual point, however, and held without limitation that "the importance of the written benefit plan is not inviolable, but is subject-based upon equitable doctrines

and principles—to modification and, indeed, even equitable reformation under § 502(a)(3)." Pet. App. 15a. It declined to limit reformation to cases of "intentional misrepresentations by the employer and fiduciary," as had this Court, but instead read into CIGNA an unmentioned "broader" principle: namely, that "when courts were sitting in equity in the days of the divided bench (or even when they apply equitable principles today) contractual language was not as sacrosanct as it is normally considered to be when applying breach of contract principles at common law." Id. There simply is no warrant in CIGNA (or any of the other sources the panel cited) for that sweeping departure from ERISA's long-standing focus on the benefit plan's written terms.

3. The decision below already has been severely criticized by one district court, which catalogued in detail the ways the Third Circuit strayed from this Court's decisions. See Schwade, supra, 2011 WL 5459649. As Schwade observed, ERISA plans are voluntary, so "encouraging an employer to volunteer requires, as explained throughout ERISA's case law. both predictable regulation and reliable construction of the plan." Id. at *17. That is precisely why the approach taken by the Third Circuit is so pernicious: "[E]veryman's notion of equity is uncertain and variable. * * * Although perhaps momentarily gratifying to the sensibilities of a judge, foisting an involuntary and unpredictable obligation on an ERISA plan endangers both the statutory ERISA regime and the salutary benefits broadly available as a result of the regime." Id. at *17, *20.

The Schwade court was equally critical of the Third Circuit's assertion that enforcing the reimbursement provision would give US Airways a "windfall." See Pet. App. 16a. Wrote the court:

Were McCutchen's employer compelled to provide a plan, were that plan immune from insolvency, were money but manna from heaven. the pejorative term "windfall" might apply. Needless to say, none of those assumptions is true. McCutchen leaves a mystery: How can a plan obtain a "windfall" by merely enforcing a contractual right that protects plan assets? "Windfall" means unearned money; McCutchen's ERISA plan sought re-imbursement of money paid by the plan and owed by McCutchen. * * * If McCutchen's ungoverned notion of equity becomes pandemic, consistent plan operation becomes impossible, inconsistent judicial ruling becomes commonplace, and some beneficiaries become profiteers at the expense of others. [Schwade, supra, 2011 WL 5459649, at *20.]

That is exactly right. The decision below is not just wrong and in conflict with other circuits; it is dangerous to boot. This Court's intervention is required.

III. THE CONFLICT AMONG THE CIRCUITS CONCERNS AN IMPORTANT, RECURRING ISSUE THAT SHOULD BE DECIDED BY THIS COURT.

Finally, there can be no question that the question presented is sufficiently important to warrant review. ERISA governs the interactions between the majority of employees and their employers across the country—tens of millions of people and thousands of plans. Section 502(a) provides the primary enforcement mechanism for all of those stakeholders. It is a fixture in the federal courts—which, no doubt, explains why this Court so frequently has been called

upon to interpret it. And the need for review, and correction, is particularly urgent here because the Third Circuit's approach threatens the viability of the ERISA plans that provide so many Americans with their health coverage.

- 1. "Employment-based health benefits plans are * * * the dominant source of health coverage in the United States," with over half of the nation's entire population covered by these plans. P. Fronstin, Sources of Health Insurance & Characteristics of the Uninsured: Analysis of the March 2011 Current Population Survey, Employee Benefit Res. Inst. Issue Brief 362, Sept. 2011, at 4.3 As Congress recognized in enacting ERISA, "the continued well-being and security of millions of employees and their dependents are directly affected by these plans." 29 U.S.C. § 1001(a).
- 2. In recent years, however, "the cost of providing health benefits" has "outpace[d] increases in worker earnings, in some years by a factor of four or five." Fronstin, supra, at 10. As a result, "[t]he percentage of individuals with employment-based health benefits decreased from 69.3 percent in 2000 to 58.7 percent in 2010." Id. Even a one-percent increase in costs has devastating effects: "each one percent increase in managed care plans' costs * * * results in a potential loss of insurance coverage for about 315,000 individuals." Health Economics Practice, Barents Group, LLC, Impacts of Four Legislative

³ Available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-2011_No362_Uninsured1.pdf.

Provisions on Managed Care Consumers: 1999-2003, at iii (1998).4

That sort of plan-killing cost increase would follow from the Third Circuit's rule. Reimbursement from third-party recoveries is essential for the solvency of many ERISA plans. See Br. of Amicus Curiae Central States, Southeast & Southwest Areas Health & Welfare Fund in Support of Petitioners, Knudson, 534 U.S. 204 (No. 99-1786), 2001 WL 492255, at *2 (plan benefit levels are based on "actuarial assumptions which assume a certain level of subrogation recoveries"; thus "such recoveries are necessary to provide assets sufficient to fund" promised benefits). Indeed, estimates suggest that plans recover more than \$1 billion annually under reimbursement provisions. Br. of Amicus Curiae America's Health Ins. Plans, Inc. et al. in Support of Respondent, Sereboff, 547 U.S. 356 (No. 05-260), 2006 WL 460877, at *3 n.3. If ERISA plans—in particular, self-funded plans—are not able to recoup their losses using this important tool, the result will be "either * * * reduced health care benefits, or higher out-ofpocket costs for participants in the form of higher copayments and deductibles, or both." Mot. of Self-Insurance Inst. of Am., Inc. for Leave to File a Brief Amicus Curiae in Support of Petitioners, Knudson, 534 U.S. 204 (No. 99-1786), 2001 WL 456442.

Moreover, the Third Circuit's ruling will introduce significant uncertainty—and significant new costs into plan administration and litigation. Litigation costs will increase because ERISA plans will have to demonstrate the propriety of reimbursement on a

⁴ Available at http://www.uhia.net/web-storage/webstorage5/ Impact%20of%20Four%20Legislative%20Provisions%20-%20 Barrents%20Group.pdf.

case-by-case basis. Plans that have members in many states, as most large plans do, will be able to enforce their contractual language against some members but not against others. And the McCutchen rule will spark forum shopping in cases involving those large plans. After all, Section 502(a) lawsuits may be brought "in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found," 29 U.S.C. § 1132(e) (emphasis added), and some courts have interpreted that to mean venue is proper in any district with which a plan has minimum contacts. See Waeltz v. Delta Pilots Retirement Plan, 301 F.3d 804, 809 (7th Cir. 2002); I.A.M. Nat'l Pension Fund v. Wakefield Indus., Inc., 699 F.2d 1254, 1257 (D.C. Cir. 1983). If the Third Circuit's decision stands, plan participants from across the country will flood that Circuit's courts with declaratory judgment actions, arguing that the plan has minimum contacts in a Third Circuit state and attempting to avail themselves of McCutchen's unprecedented rule.

These are precisely the sorts of ERISA-distorting errors this Court has previously granted certiorari to correct. In Conkright, for example, the Court reviewed and reversed a decision that—like the decision below—had the effect of "interject[ing] other additional issues into ERISA litigation," thereby "increas[ing] litigation costs." 130 S. Ct. at 1649-50. In overturning the lower court's decision to limit the deference owed an ERISA plan administrator, this Court recognized the "uniformity problems that arise from creating ad hoc exceptions" affecting the enforcement of ERISA plans. Id. at 1650. That perfectly describes the Third Circuit's decision to interject

ad hoc equitable determinations into the enforcement of unambiguous reimbursement provisions.

- 3. This Court, of course, has recognized the particular importance of Section 502(a)(3) by opining repeatedly on its proper interpretation and scope. See CIGNA, 131 S. Ct. 1866; Sereboff, 547 U.S. 356; Knudson, 534 U.S. 204; Harris Trust & Savings Bank, Inc. v. Salomon Smith Barney Inc., 530 U.S. 238 (2000); Varity Corp., 516 U.S. 489; Mertens, 508 U.S. 248; Russell, 473 U.S. 134. The issue presents itself frequently in the lower courts too. To offer two illustrations: Sereboff's holding concerning "appropriate equitable relief' under Section 502(a)(3) has been invoked in some 260 cases in less than six years. And this Court decided CIGNA less than a year ago, yet its discussion of equitable reformation in the ERISA context already has been cited by courts 34 times. There can be no question that the meaning of Section 502(a)(3) is an "important and recurring" issue worthy of review. Stern & Gressman at 228.
- 4. Finally, this case presents an excellent vehicle to resolve the question recognized, but left undecided, in Sereboff. The case "squarely presents" the issue, as the court below recognized. Pet. App. 9a. The factual record is well-developed and undisputed in all relevant parts. The circuit split is well-defined, outcome-determinative, and conceded by the decision below. See Pet. App. 13a-14a; see also Sereboff, 547 U.S. at 361 (granting certiorari where court below had recognized a circuit conflict concerning Section 502(a)(3)). And the time is right for review: Half the circuits have weighed in; they are irrevocably split; and for the reasons just discussed, the Third Circuit's decision will quickly begin causing administra-

tive complications, distorting litigation choices, and increasing the costs and complexity of litigation—just what ERISA was designed to prevent. Given the square conflict and the importance of the issue presented, there is no reason for this Court to let it percolate any longer. Review is not just appropriate; it is essential.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

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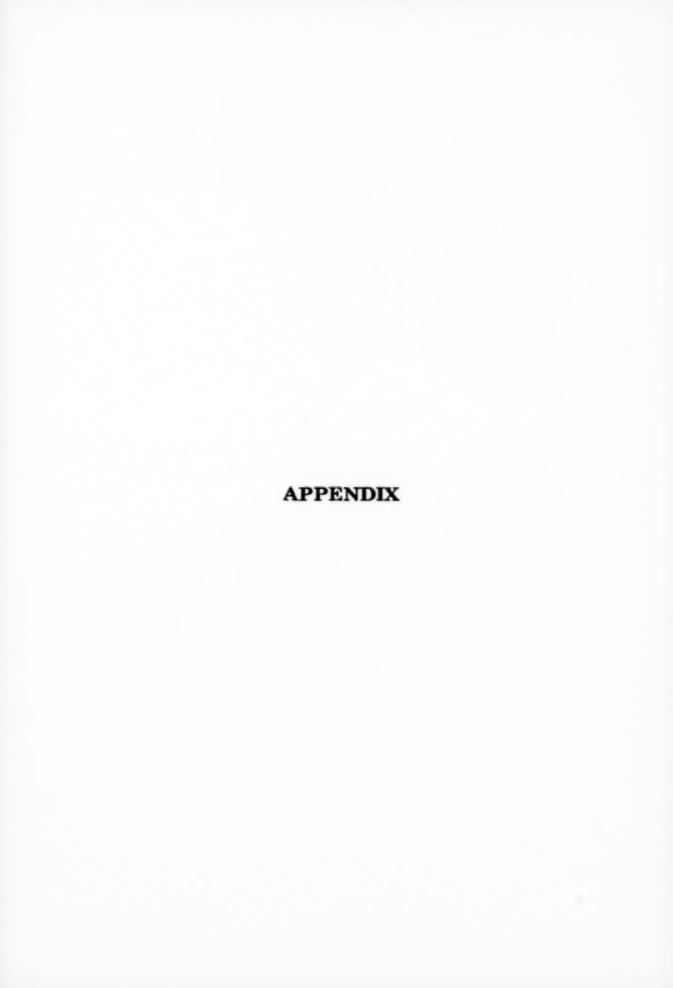
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Respectfully submitted.

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April 2012



APPENDIX A

PRECEDENTIAL

In the United States Court of Appeals Third Circuit

No. 10-3836

US AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the US Airways, Inc. Employee Benefits Plan

V.

JAMES E. MCCUTCHEN; ROSEN LOUIK & PERRY, P.C.,

Appellants

On Appeal from the District Court for the Western District of Pennsylvania (No. 2-08-cv-01593)

District Judge: Honorable David Stewart Cercone

Argued: July 11, 2011

Before: SLOVITER, FUENTES, and VANASKIE, Circuit Judges

(Opinion Filed: November 16, 2011)

OPINION OF THE COURT

FUENTES, Circuit Judge:

After Appellant James McCutchen suffered a accident, a benefit plan serious automobile administered by US Airways paid \$66,866 for his McCutchen then recovered medical expenses. \$110,000 from third parties, with the assistance of counsel. Then US Airways, which had not sought to enforce its subrogation rights. demanded reimbursement of the entire \$66,866 it had paid without allowance for McCutchen's legal costs, which had reduced his net recovery to less than the amount it demanded. US Airways filed this suit against "appropriate equitable McCutchen for pursuant to § 502(a)(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1132(a)(3)(B). The issue before us is whether McCutchen may assert certain equitable limitations, such as unjust enrichment, on US Airways' equitable claim. We conclude that he may. We therefore vacate the District Court's order requiring McCutchen to pay US Airways the entire \$66.866 and remand the case for that Court to fashion "appropriate equitable relief."

This case stems from a tragic car accident in which a young driver lost control of her car, crossed the median of the road, and struck a car driven by 51vear-old James McCutchen. Then the traveling behind McCutchen also slammed into his car. The accident killed one person and left two others with severe brain injuries. McCutchen himself was grievously injured and survived only after emergency surgery. He spent several months in physical therapy and ultimately underwent a complete hip replacement. Since the accident, McCutchen, who had a history of back surgeries and associated chronic pain, has also become unable to effectively treat that pain with medication. accident has rendered him functionally disabled. McCutchen's Health Benefit Plan (the "Plan"). administered and self-financed by US Airways, paid medical expenses in the amount of \$66,866 on his behalf.

After the accident, McCutchen, through his attorneys at Rosen Louik & Perry, P.C., filed an action against the driver of the car that caused the accident. Because she had limited insurance coverage, and because three other people were seriously injured or killed, McCutchen settled with the other driver for only \$10,000. However, with his lawyers' assistance, he and his wife received another \$100,000 in underinsured motorist coverage for a total third-party recovery of \$110,000. After paying a 40% contingency attorneys' fee and expenses, his net recovery was less than \$66,000. US Airways demanded reimbursement for the entire \$66,866 that it had paid for McCutchen's medical bills. Soon

after, Rosen Louik & Perry placed \$41,500 in a trust account, reasoning that any lien found to be valid would have to be reduced by a proportional amount of legal costs. The record on appeal does not establish what amount was disbursed to McCutchen.

When McCutchen did not pay, US Airways, in its capacity as administrator of the ERISA benefits plan, filed suit in the District Court under § 502(a)(3) of ERISA, seeking "appropriate equitable relief" in the form of a constructive trust or an equitable lien on the \$41,500 held in trust and the remaining \$25,366 personally from McCutchen. The Summary Plan Description describing the US Airways benefits plan covering McCutchen contained the following paragraph, entitled "Subrogation and Right of Reimbursement":

The purpose of the Plan is to provide coverage for qualified expenses that are not covered by a third party. If the Plan pays benefits for any claim you incur as the result of negligence, willful misconduct, or other actions of a third party, the Plan will be subrogated to all your rights of recovery. You will be required to reimburse the Plan for amounts paid for claims out of any recovered from monies a third including, but not limited to, your own insurance company as the result judgment, settlement, or otherwise. In addition you will be required to assist the administrator of the Plan in enforcing these and may not negotiate agreements with a third party that would undermine the subrogation rights of the

Plan.

(App. 117) (emphasis added). Thus, under the Plan Description, a beneficiary is required to reimburse the Plan for any amounts it has paid out of any monies the beneficiary recovers from a third party.

US Airways claims that this language permits it to recoup the \$66,866 it provided for McCutchen's medical care out of the \$110,000 total that he recovered regardless of his legal costs. It argues that "Nile Plan language specifically authorized reimbursement in the amount of benefits paid, out of any recovery." (Appellee's Br. at 15-16).

McCutchen says that it would be unfair and inequitable to reimburse US Airways in full when he has not been fully compensated for his injuries, including pain and suffering. He argues that US Airways, which made no contribution to his attorneys' fees and expenses, would be unjustly enriched if it were now permitted to recover from him without any allowance for those costs, in essence to reap what McCutchen has sown. Indeed, if legal costs are not taken into account, US Airways will effectively be reaching into its beneficiary's pocket, putting him in a worse position than if he had not pursued a third-party recovery at all.

Citing the Plan's use of the language "any monies recovered," as well as our previous decisions, the District Court rejected McCutchen's arguments and granted summary judgment to US Airways. The Court required McCutchen to sign over the \$41,500 held in trust and to pay \$25,366 from his own funds.

McCutchen appeals.1

П.

A.

Congress designed ERISA to protect employee and benefits by providing pension pensions enumerating insurance. certain specific characteristics of pension and benefit plans, and setting forth fiduciary duties for the managers of both pension and nonpension plans. Varity Corp. v. Howe, 516 U.S. 489, 496 (1996). The Supreme Court repeatedly observed that "ERISA comprehensive and reticulated statute, the product of a decade of congressional study of the Nation's private employee benefit system." Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 209 (2002) (quoting Mertens v. Hewitt Assocs., 508 U.S. 248, 251 (1993)) (internal quotation marks omitted). Courts have therefore been reluctant to tamper with its carefully crafted and detailed enforcement scheme. Id. Under this scheme, Congress gave plan beneficiaries greater rights than plan fiduciaries to enforce the terms of a benefit plan. A beneficiary has

The District Court had jurisdiction over this matter under 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e)(1). We have jurisdiction over McCutchen's appeal under 28 U.S.C. § 1291. "We exercise plenary review over a district court's summary judgment ruling." Disabled in Action of Pa. v. Se. Pa. Transp. Auth., 635 F.3d 87, 92 (3d Cir. 2011) (quoting Melrose Inc. v. City of Pittsburgh, 613 F.3d 380, 387 (3d Cir. 2010)). "Summary judgment is appropriate only where, drawing all reasonable inferences in favor of the nonmoving party, there is no genuine issue as to any material fact and . . . the moving party is entitled to judgment as a matter of law." Id. (quoting Melrose Inc., 613 F.3d at 387)).

a general right of action "to enforce his rights under the terms of the plan." Knudson, 534 U.S. at 221 (quoting 29 U.S.C. § 1132(a)(1)(B)). By contrast, a fiduciary's right to enforce plan terms is governed by ERISA's § 502(a)(3), which limits the available relief to an injunction or "other appropriate equitable relief." 29 U.S.C. § 1132(a)(3); Knudson, 534 U.S. at 221; Sereboff v. Mid Atlantic Medical Servs., Inc., 547 U.S. 356, 361 (2006). It is under this provision that US Airways seeks to enforce the Plan's subrogation and reimbursement provision against McCutchen.

The Supreme Court has explained that the modifier "appropriate equitable relief is not superfluous. Mertens, 508 U.S. at 257-58. Rather, "Congress's choice to limit the relief available under § 502(a)(3) to 'equitable relief requires us to recognize the difference between legal and equitable forms of restitution." Knudson, 534 U.S. at 218. Thus, the Supreme Court has "interpreted the 'appropriate equitable relief in § 502(a)(3) as those categories of relief that, referring to traditionally speaking (i.e., prior to the merger of law and equity) were typically available in equity." Cigna Corp. v. Amara, 131 S. Ct. 1866, 1878 (2011) (quoting Sereboff, 534 U.S. at 361) (internal quotation marks omitted).

The Supreme Court has twice considered what this limitation means in the context of a fiduciary's action for reimbursement from a beneficiary under an ERISA plan. In Great-West Life & Annuity Insurance Co. v. Knudson, the Court first considered whether an ERISA plan administrator's claim for reimbursement was equitable in nature. See 534

U.S. at 210-12. To decide this question, the Court examined cases and secondary legal materials to determine whether the relief would have been equitable "[i]n the days of the divided bench." Id. at 212. As the Court explained, one feature of equitable restitution was that it sought to impose a constructive trust or equitable lien on "particular funds or property in the defendant's possession." Id. at 213. The Court held that this requirement was not met in Knudson because the funds to which the plan claimed an entitlement had been placed in a "Special Needs Trust" under California law. Id. at 214.

In Sereboff v. Mid Atlantic Medical Services, Inc., the Court again considered an ERISA plan administrator's claim for reimbursement under the terms of the plan and § 502(a)(3). See 547 U.S. at 359. This time the plan administrator was able to overcome the initial hurdle of identifying specific funds within the beneficiary's possession and control. Id. at 362-63. Accordingly, the Court proceeded to consider whether there was a basis in equity for the administrator's reimbursement claim. See id. at 363-64. It held that the claim could be based on an equitable lien by agreement. Id. at 364-65 (citing Barnes v. Alexander, 232 U.S. 117 (1914)). Such a lien is not subject to the asset tracing requirements imposed on liens sought as a matter of equitable restitution. Id. at 365. Nor is it inherently subject to the particular equitable defenses that accompany a freestanding action for equitable subrogation, which may only be asserted after a victim has been made whole for his injuries. Id. at 368. Thus, the Court held that the plan administrator in Sereboff properly

sought "equitable relief" under § 502(a)(3). Id. at 369. However, it expressly reserved decision on whether the term "appropriate," which modifies "equitable relief" in § 502(a)(3), would make equitable principles and defenses applicable to a claim under that section. Id. at 368 n.2.

This case squarely presents the question that Sereboff left open: whether § 502(a)(3)'s requirement that equitable relief be "appropriate" means that a fiduciary like US Airways is limited in its recovery from a beneficiary like McCutchen by the equitable defenses and principles that were "typically available in equity."

B.

McCutchen argues that the phrase "appropriate equitable relief" means more than just that the relief US Airways seeks must be of an equitable type; courts must also exercise their discretion to limit that relief to what is "appropriate" under traditional equitable principles. In particular, he argues that the principle of unjust enrichment frames US Airways' claim. We agree.²

² Before the District Court, McCutchen also argued for application of the "make-whole" doctrine, which is an equitable doctrine, applied in many states, that provides that "the insured is entitled to be made whole before the insurer recovers on its subrogation claim." 16 Lee R. Russ in conjunction with Thomas F. Segalla, Couch on Insurance § 223:133 (3d ed. 2011); see, e.g., Swanson v. Hartford Ins. Co. of Midwest, 46 P.3d 584, 589 (Mont. 2002) ("[A]n insured must be totally reimbursed for all losses as well as costs, including attorney fees, involved in recovering those losses before the insurer can exercise any right of subrogation, regardless of any contract language providing to the contrary.") (internal quotation omitted). McCutchen does not pursue this argument on appeal, and we do not address it.

The Supreme Court reasoned in Knudson that "equitable relief must mean something less than all relief." Knudson, 534 U.S. at 209 (quoting Mertens, 508 U.S. at 258 n.8) (emphasis in original). Therefore, a fund administrator seeking to enforce a plan's reimbursement provision must demonstrate that its claim to relief is equitable. Sereboff, 547 By the same logic, "appropriate U.S. at 363. equitable relief' must be something less than all equitable relief. See Mertens, 508 U.S. at 258 ("We will not read the statute to render the modifier The word "appropriate" means superfluous."). "specially suitable," "belonging peculiarly [to]," or "attached as an accessory possession." Webster's Third New International Dictionary 106 (1993). Remedies that peculiarly belong to traditional categories of equitable relief would typically have been defeated by equitable principles and defenses.

Indeed, it would be strange for Congress to have intended that relief under § 502(a)(3) be limited to traditional equitable categories, but not limited by other equitable doctrines and defenses that were traditionally applicable to those categories. "[S]tatutory reference to [an equitable] remedy must, absent other indication, be deemed to contain the limitations upon its availability that equity typically imposes." Knudson, 534 U.S. at 211 n.1 (rejecting the argument that a reimbursement claim framed as a claim for injunctive relief could proceed under § 502(a)(3) without a showing that the relief sought was typically available in equity); see also Cigna, 131 1880 ("Section 502(a)(3) invokes the S. Ct. at equitable powers of the District Court."). Accordingly, in light of the foregoing reasoning, and in the absence of any indication in the language or structure of § 502(a)(3) to the contrary, we find that Congress intended to limit the equitable relief available under § 502(a)(3) through the application of equitable defenses and principles that were typically available in equity.

To determine what types of relief were typically available in equity, the Supreme Court endorsed consultation of "standard current works such as Dobbs, Palmer, Corbin, and the Restatements, which make the answer clear." Knudson, 534 U.S. at 217; see Sereboff: 547 U.S. at 368 (citing 4 George Palmer. Law of Restitution § 23.18 (1978)). We consult the same works to determine whether that equitable relief is "appropriate" in light of equitable principles and defenses that were typically applied. sources all support McCutchen's position that the principle of unjust enrichment is broadly applicable to claims for equitable relief. See 1 Dan Dobbs, Law of Remedies § 4.3(3), at 602 (2d ed. 1993) (noting that equitable remedies such as constructive trusts and equitable liens are all "invoked for the same reason, to prevent unjust enrichment"); 1 Palmer, Law of Restitution § 1.1, at 4 ("In equity the principal remedy is constructive trust; but equitable lien, and accounting subrogation. are techniques frequently used to prevent unjust enrichment."). This animating principle of equity clearly applies to trustee's claim for reimbursement from beneficiary. "Equity courts possessed the power . . . to prevent [a] trustee's unjust enrichment." Cigna, 131 S. Ct. at 1880 (citing Restatement (Third) of Trusts § 95, and Comment a (Tent. Draft No. 5, Mar. 2, 2009)); see also 4 Palmer, Law of Restitution

§ 23.18 at 472-74 ("[T]he principle of unjust enrichment . . . should serve to limit the effectiveness of contract provisions which in terms provide for reimbursement out of the insured's tort recovery without regard to whether or the extent to which, that recovery includes medical expense.").

C.

Against this conclusion, US Airways cites to prior decisions of this Court in which we declined to fashion a federal common law rule limiting an ERISA plan administrator's right to reimbursement under the plan's terms. See Ryan ex rel. Capria-Ryan v. Fed. Express. 78 F.3d 123 (3d Cir. 1996): Bollman Hat Co. v. Root, 112 F.3d 113 (3d Cir. 1997); see also Bill Gray Enterprise v. Gourley, 248 F.3d 206, 220 n.13 (3d Cir. 2001). While we recognize that the District Court may have considered itself bound by these cases, each came before the Supreme Court's decisions in Knudson and Sereboff, which clarified the meaning of "appropriate equitable relief in § 502(a)(3), specified its central importance to fiduciaries' reimbursement suits under ERISA, and thereby undermined the reasoning and holdings of our prior decisions. Our prior opinions in Ryan, Bollman Hat, and Gourley did not consider whether "appropriate equitable phrase relief § 502(a)(3) limits a fiduciary's right to relief. In fact, none of these cases even referenced § 502(a)(3). These cases are therefore inapposite in light of the Supreme Court's intervening decisions. See In re Krebs, 527 F.3d 82, 84 (3d Cir. 2008) ("A panel of this Court may reevaluate the holding of a prior panel which conflicts with intervening Supreme Court precedent."); see also Gately v. Mass., 2 F.3d 1221,

1226 (1st Cir. 1993) (noting that under "[t]he essential principles of stare decisis... if an issue is not argued, or though argued is ignored by the court... the decision does not constitute a precedent to be followed").3

US Airways next cites cases from other Courts of Appeals, some of which were decided after Sereboff, to support its position that equitable doctrines that might limit its reimbursement recovery are not applicable under § 502(a)(3). See Zurich Am. Ins. Co. v. O'Hara, 604 F.3d 1232 (11th Cir. 2010); Admin. Comm. of Wal-Mart Stores, Inc. Assoc. Health & Welfare Plan v. Shank, 500 F.3d 834 (8th Cir. 2007); Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough, 354 F.3d 348 (5th Cir. 2003); Admin. Comm. of the Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Varco, 338 F.3d 680 (7th Cir. 2003). Like our pre-Sereboff decisions, these cases frame the question of whether equitable principles limit the scope of an administrator's right to reimbursement as a question of whether federal common law can override the

³ Even under our prior cases, US Airways' claim to reimbursement from McCutchen's pocket is unprecedented. We declined to pass on the permissibility of such a claim in Bollman Hat, where amicus contended that mechanically enforcing a plan's reimbursement terms "will lead to inequitable results where a plan participant's third party recovery is less than the plan's subrogation claim plus attorney's fees." 112 F.3d at 117. Because the participant's third party settlement fully financed his attorney's fees and the reimbursement claim in that case, we declined to address "hypothetical scenarios." Id.; see also Ryan, 78 F.3d at 124-25 (noting that plan's terms limited reimbursement to a beneficiary's net recovery after legal expenses).

express language of benefit plans. See, e.g., O'Hara, 604 F.3d at 1237 ("Applying federal common law to override the Plan's controlling language, which expressly provides for reimbursement regardless of whether [insured] was made whole . . . would frustrate, rather than effectuate ERISA's purpose to protect contractually defined benefits") (internal quotation marks omitted); Shank, 500 F.3d at 837 ("We are not persuaded that the Committee's full recovery according to the terms of the plan is not 'appropriate' relief within the meaning of ERISA" because "we generally adopt new rules of federal common law only if they are necessary to fill gaps left by the express provisions of ERISA and to effectuate the purposes of the statute."); cf. Ryan, 78 F.3d at 127 (refusing to recognize a new federal "common law right" under ERISA). "[a]mong the primary purposes of ERISA is to ensure the integrity of written plans," these courts refused to "apply common law theories to alter the express terms of a written plan." Shank, 500 F.3d at 838.

We disagree with those circuits that have held that it would be pioneering federal common law to apply equitable limitations on an equitable Congress purposefully limited the relief available to 503(a)(3)fiduciaries under 8 to "appropriate See Knudson, 534 U.S. at 209. equitable relief." While our sister circuits pay homage to this language, they appear to reason that its requirement has been met so long as the suit can be properly characterized as an equitable action, without also asking whether the relief sought in the action is "appropriate" under traditional equitable principles and doctrines. But the Supreme Court has rejected a permissive reading of this language that would mean "all relief available for breach of trust at common law" because "[t]he authority of courts to develop a 'federal common law' under ERISA is not the authority to revise the text of the statute." Mertens, 508 U.S. at 258-59 (citation omitted). By categorically excluding the equitable limitations that § 502(a)(3)'s reference to equitable remedies necessarily contains, the Shank and O'Hara courts depart from the text of ERISA. See Knudson, 534 U.S. at 211 n.1.

Moreover, as the Supreme Court recently demonstrated in Cigna, the importance of the written benefit plan is not inviolable, but is subjectbased upon equitable doctrines and principles—to modification and, indeed, even equitable reformation under § 502(a)(3). 131 S. Ct. at 1879 (finding that the District Court's "reformation of the terms of the plan, in order to remedy the false or misleading information CIGNA provided [was within] a traditional power of an equity court"). While the basis for the reformation in Cigna was intentional misrepresentations by the employer and fiduciary, the broader and more relevant point is that when courts were sitting in equity in the days of the divided bench (or even when they apply equitable principles today) contractual language was not as sacrosanct as it is normally considered to be when applying breach of contract principles at common law. We do not suggest that US Airways' conduct was fraudulent or dishonest in the way that Cigna's was, but equitable principles can apply even where no one has committed a wrong.

Thus, we agree that one of Congress's purposes in

enacting ERISA was to "ensure the integrity of written, bargained-for benefit plans." O'Hara, 604 F.3d at 1236. But, as demonstrated by the language of § 502(a)(3) and now Cigna, Congress expressly tempered that purpose by limiting fiduciaries to "appropriate equitable relief," thus invoking principles that it surely knew are sometimes less deferential to absolute freedom of contract. In other words, "vague notions of a statute's basic purpose are . . . inadequate to overcome the words of its text regarding the specific issue under consideration." Knudson, 534 U.S. at 220 (quoting Mertens, 508 U.S. at 261) (emphasis in original).

Finally, US Airways raises a practical concern that the application of equitable principles will increase plan costs and premiums. This concern does not address the statutory language and is, in any event, unsubstantiated by the circumstances of this case. US Airways cannot plausibly claim it charged lower premiums because it anticipated a windfall.

D.

Applying the traditional equitable principle of unjust enrichment, we conclude that the judgment requiring McCutchen to provide full reimbursement to US Airways constitutes inappropriate and inequitable relief. Because the amount of the judgment exceeds the net amount of McCutchen's third-party recovery, it leaves him with less than full payment for his emergency medical bills, thus undermining the entire purpose of the Plan. At the same time, it amounts to a windfall for US Airways, which did not exercise its subrogation rights or contribute to the cost of obtaining the third-party recovery. Equity abhors a windfall. See Prudential

Ins. Co. of America v. S.S. American Lancer, 870 F.2d 867, 871 (2d Cir. 1989).

Therefore, we will vacate the District Court's final judgment. We do not decide on appeal what would constitute appropriate equitable relief for US Airways because "equity calls for full factual findings rather than our speculation." Nat'l City Mortg. Co. v. Stephen, 647 F.3d 78, 87 n.8 (3d Cir. 2011); see also, e.g., Hecht Co. v. Bowles, 321 U.S. 321, 329 (1944) ("The essence of equity jurisdiction has been the power of the Chancellor to do equity and to mould each decree to the necessities of the particular case."); see generally Holland v. Florida, 130 S: Ct. 2549, 2563 (2010) (discussing the bounded flexibility of courts of equity). Instead, we will remand for the District Court to "exercise its discretion under § 502(a)(3)." Cigna, 131 S. Ct. at 1880.

On remand, the District Court should engage in any additional fact-finding it finds necessary. In addition to the considerations discussed above, factors such as the distribution of the third-party recovery between McCutchen and his attorneys at Rosen Louik & Perry, the nature of their agreement, the work performed, and the allocation of costs and risks between the parties to this suit may inform the Court's exercise of its discretion to fashion "appropriate equitable relief."

III.

Because we conclude that US Airways' claim for reimbursement under § 502(a)(3) of ERISA is subject to equitable limitations, we will vacate the District Court's final judgment and remand for further proceedings consistent with this opinion.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA

US AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the)))
US Airways, Inc. Employee Benefits Plan,)
Plaintiff,)))
vs.)
JAMES E. MCCUTCHEN; and ROSEN, LOUIK & PERRY, P.C.,)))
Defendants.)
	(

MEMORANDUM OPINION

August 30, 2010

I. INTRODUCTION

Plaintiff, US Airways, Inc. ("US Airways"), in its capacity as fiduciary and administrator of the US Airways, Inc. Health Benefit Plan (the "Plan"), filed

this action against Defendants, James E. McCutchen ("McCutchen") and the law firm of Rosen, Louik and Perry, PC ("RL&P") seeking equitable relief under Section 502(a)(3) of the Employee Retirement Income Security Act of 1974, as amended, ("ERISA"), 29 U. S. C. § 1132(a)(3), to enforce certain subrogation/reimbursement provisions of the Plan. US Airways has filed a motion for summary judgment, Defendants have responded and the motion is now before the Court.

II. STATEMENT OF THE CASE

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On January 24, 2007, McCutchen sustained multiple injuries in an automobile accident (the "Accident"). Plaintiffs Concise Statement of Undisputed Material Facts ("Pl. SUMF") ¶ 4; Affidavit of Jon Perry ("Perry Aff.") ¶¶ 2 & 3. At the time of the accident, McCutchen was an employee of US Airways, and allegedly a beneficiary under the Plan which provided medical expense benefits to its participants. Pl. SUMF ¶ 3. The Plan paid accident-related medical expenses on behalf of McCutchen in the amount of \$66,865.82. Pl. SUMF ¶ 5.

Attorney Jon R. Perry and the law firm of Rosen, Louik and Perry, PC were retained by the McCutchens to pursue claims related to the accident. Pl. SUMF ¶ 6; Perry Aff. ¶ 2. In June of 2007, Perry and RL&P were notified by Ingenix Subrogation Services ("Ingenix") that it had been retained by the Plan to recover medical benefits paid by the Plan on behalf of McCutchen for treatment of injuries arising out of the Accident. Pl. SUMF ¶ 7; Perry Aff. Exhibit 1. McCutchen denied the Plan's right to reimbursement out of any settlement proceeds.

Pl. SUMF ¶ 9. McCutchen's claims were eventually settled for \$10,000.00 from the driver whose vehicle struck McCutchen's, and \$100,000.00 in underinsured motorist benefits (the "UIM Claim"), the limits of the policy, under McCutchen's automobile insurance policy. Perry Aff. ¶¶ 6, 7, 10 &11.

RL&P deducted its fee and a proportionate share of the expenses from the total settlement and placed \$41,500.00 in its trust account for any lien against McCutchen found to be valid. Perry Aff. Exhibit 21; Pl. SUMF ¶¶ 13 & 14. The Plan is seeking the \$41,500.00 held by RL & P, as well as \$25,365.82 allegedly in the possession of McCutchen. Defendants contend that the Plan does not have an enforceable lien in this matter.

III. LEGAL STANDARD FOR SUMMARY JUDGMENT

Pursuant to FED. R. CIV. P. 56(c), summary judgment shall be granted when there are no genuine issues of material fact in dispute and the movant is entitled to judgment as a matter of law. To support denial of summary judgment, an issue of fact in dispute must be both genuine and material. i.e., one upon which a reasonable fact finder could base a verdict for the non-moving party and one which is essential to establishing the claim. Anderson v. Liberty Lobby, 477 U.S. 242, 248 (1986). When considering a motion for summary judgment, the court is not permitted to weigh the evidence or to make credibility determinations, but is limited to deciding whether there are any disputed issues and, if there are, whether they are both genuine and material. Id. The court's consideration of the facts

must be in the light most favorable to the party opposing summary judgment and all reasonable inferences from the facts must be drawn in favor of that party as well. Whiteland Woods, L.P. v. Township of West Whiteland, 193 F.3d 177, 180 (3d Cir. 1999), Tigg Corp. v. Dow Corning Corp., 822 F.2d 358, 361 (3d Cir. 1987).

When the moving party has carried its burden under Rule 56(c), its opponent must do more than simply show that there is some metaphysical doubt as to the material facts. See Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 586 (1986). In the language of the Rule, the nonmoving party must come forward with "specific facts showing that there is a genuine issue for trial." FED. R. CIV. P 56(e). Further, the nonmoving party cannot rely on unsupported assertions, conclusory allegations, or mere suspicions in attempting to survive a summary judgment motion. Williams v. Borough of W. Chester, 891 F.2d 458, 460 (3d Cir.1989) (citing Celotex Corp. v. Catrett, 477 U.S. 317, 325 (1986)). The non-moving party must respond "by pointing to sufficient cognizable evidence to create material issues of fact concerning every element as to which the non-moving party will bear the burden of proof at trial." Simpson v. Kay Jewelers, Div. of Sterling, Inc., 142 F. 3d 639, 643 n. 3 (3d Cir. 1998), quoting Fuentes v. Perskie, 32 F.3d 759, 762 n.1 (3d Cir. 1994).

IV. DISCUSSION

ERISA expressly authorizes fiduciaries of ERISAgoverned plans to sue to seek redress of violations or enforce provisions of ERISA or of particular plans. 29 U.S.C. § 1132(a)(3). Further, where an ERISA-governed plan seeks to impose a constructive trust or equitable lien on "particular funds or property in the defendant's possession," such plan is seeking equitable restitutionary relief as contemplated by ERISA under § 502(a)(3). Sereboff v. Mid-Atlantic Medical Services, 547 U.S. 356, 361-362 (2006). Here, US Airways is seeking to enforce certain subrogation/reimbursement provisions of the Plan.

As an initial matter, Defendants argue that there is an issue of fact regarding whether McCutchen was actually covered by the US Airways, Inc. Health Benefit Plan. The Court finds such contention to be without merit. There is no dispute that at the time of the accident, McCutchen was an employee of US Airways. US Airways has explained the confusion regarding McCutchen's coverage which occurred in an out-of-court representation early in this litigation. See U.S Airways Appendix, Ex. 1, Affidavit of Kimie Shanahan¹ ("Shanahan Aff.") ¶¶ 4 & 5. Moreover, Defendants have offered no material evidence to the Because the Court finds that the US Airways, Inc. Health Benefit Plan is the applicable ERISA plan in this matter, the Court must also find that the Plan is self funded. See Shanahan Aff. ¶ 3: Exhibit 1 to Shanahan Affidavit, p. 93.

A. Review of Self-Funded ERISA Plan

The United States Supreme Court has directed courts to review a self-funded ERISA plan's interpretation of its contracts governing benefit

¹ Shanahan is employed by U.S. Airways as Manager, Benefits Services, and has been in such position since June of 2005, Shanahan Aff. ¶¶ 1 & 2.

payments under an arbitrary and capricious standard. Firestone Tire and Rubber Co. v. Bruch. 489 U.S. 101 (1989). Applying general principles of trust law, the Court further stated, "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor in determining whether there is an abuse of discretion." Id. at 115. The Third Circuit has found that an arrangement in which an employer establishes a plan, ensures its liquidity, and creates an internal benefits committee vested with the discretion to interpret the plan's terms and administer benefits, does not constitute the kind of conflict mentioned by the Court in Firestone. Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 383 (3d Cir. 2000). Regarding such self-funded ERISA plans, the court stated:

While . . . there might be a risk of opportunism [in permitting a self-funded Plan to interpret the provisions of its coverage] . . . this alone does not constitute evidence of a conflict of interest, in part because the employer "has incentives to avoid the loss of morale and higher wage demands that could result from denials of benefits."

Id. at 386 (quoting Nazay v. Miller, 949 F.2d 1323 (3d Cir. 1991)).

In Bill Gray Enters. v. Gourley, 248 F.3d 206 (3d Cir. 2001), a case factually similar to the instant case, the Court of Appeals for the Third Circuit reviewed the plan at issue under the arbitrary and capricious standard, stating:

Under the Plan document, Bill Gray, as the Plan fiduciary and administrator, was given the discretionary authority to interpret the terms of the Plan document. By instituting litigation against [Defendants], Bill Gray interpreted the Plan document to require reimbursement from payments received under an uninsured motorist benefits policy. Accordingly, we review the . . . interpretation of the Plan document under an arbitrary and capricious standard.

Bill Gray Enters. v. Gourley, 248 F.3d at 217-218 (citing Pinto v. Reliance Standard Life Ins. Co., 214 F.3d at 378). Under the "arbitrary and capricious" standard, the Court may only overturn the Claim Administrator's decisions if it is "clearly not supported by the evidence in the record or the administrator has failed to comply with procedures required by the plan." Vitale v. Latrobe Area Hosp., 420 F.3d 278, 281-82 (2005). The Court may not substitute its own judgment as to the interpretation of the plan where this heightened standard is deemed appropriate. Moats v. United Mine Workers of America Health and Retirement Funds, 981 F.2d 685, 687-88 (3d Cir. 1992).

US Airways, as Plan administrator, is solely responsible for the administration of the Plan, and has:

sole discretion to determine all matters relating to eligibility, coverage and benefits under the Plan, including entitlement to benefits. The Plan administrator will also have the sole discretion to determine all matters relating to interpretation and operation of the Plan. Any determination by the Plan administrator, or its authorized delegate, shall be final and binding.

Exhibit 1 to Shanahan Affidavit, p. 91. Like the administrator in Bill Gray, US Airways has the Plan document interpreted to require reimbursement from payments received McCutchen under his uninsured motorist benefits policy and has instituted this litigation to recover medical expenses paid by the Plan. The Court will review the Plan under the arbitrary and capricious standard.2

In reviewing US Airways' interpretation of the Plan, the Court must first determine whether the terms of the plan document are ambiguous. Bill Gray Enters. v. Gourley, 248 F.3d at 218; In re Unisys Corp. Long-Term Disability Plan ERISA Litig., 97 F.3d 710, 715-716 (3d Cir. 1996). determination of whether terms in an ERISA plan document are ambiguous is a question of law. Bill Gray Enters. v. Gourley, 248 F.3d at 218. Terms are considered ambiguous if they are subject reasonable alternative interpretations. Id.; Taylor v. Cont'l Group Change in Control Severance Pay Plan, 933 F.2d 1227, 1232 (3d Cir. 1991). In determining whether terms of the Plan are ambiguous, the Court must look to the plain language of the documents. Id.; see Henglein v. Colt Indus. Operating Corp. Informal Plan, 91 Fed. Appx. 762, 766 (3d Cir. 2004).

If the terms of the Plan at issue are unambiguous, then any actions taken by the plan administrator

² The Defendants have not argued bias or conflict of interest on the part of US Airways.

inconsistent with the terms of the document are arbitrary. Bill Gray Enters. v. Gourley, 248 F.3d at 218. Actions reasonably consistent with unambiguous plan language, however, are not arbitrary. Id. If the Court determines the terms of the Plan are ambiguous, we must analyze whether US Airways' interpretation of the document was reasonable. Id. (citing Spacek v. Maritime Ass'n ILA Pension Plan, 134 F.3d 283, 292 (5th Cir. 1998)).

Under the Plan, beneficiaries are subject to subrogation as follows:

If the Plan pays benefits for any claim you incur as the result of negligence, willful misconduct, or other actions of a third party, the Plan will be subrogated to all your rights of recovery. You will be required to reimburse the Plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, your own insurance company as the result of judgment, settlement, or otherwise. addition, you will be required to assist the administrator of the Plan in enforcing these rights and may not negotiate agreements with a third party that would undermine the subrogation rights of the Plan.

Exhibit 1 to Shanahan Affidavit, p. 72. Defendants argue that, in the area of personal injury law, the term "third party" is universally accepted as referring to the at-fault tortfeasor. Defendants argue, therefore, that the language "[y]ou will be required to reimburse the Plan for amounts paid for claims out of any monies recovered from a third

party, including, but not limited to, your own insurance company . . ." creates an ambiguity because one "cannot recover money from the third party from one's own insurance company."

In Bill Gray, the Third Circuit was presented with the same issue and found:

The term "third party" is not ambiguous because the term clearly refers to any person or entity other than the Plan and the covered individual. "Third party" broadly a fers to a variety of individuals and entities who are not "a party to a lawsuit, agreement, or other transaction." Black's Law Dictionary 1489 (7th ed. 1999). As the District Court noted, the term third party "in common parlance refers to a person or entity not an initial party to a suit or transaction who may have rights or obligations therein." Bill Gray Enter., Inc., slip op. at *15. While this provision contemplates broad rights reimbursement, we do not believe this translates into ambiguity.

Bill Gray Enters. v. Gourley, 248 F.3d at 220. Similar to the language in the US Airways' Plan, the Plan document in Bill Gray explicitly provided that reimbursement also applied "when a Covered Person recovers under an uninsured or underinsured motorist plan . . ." Id. Based upon that language, the court found that a "reasonable plan participant . . . would understand the Plan document clearly mandates any recoveries from an uninsured motorist plan are subject to reimbursement." Id.

Based on the above, this Court finds that the term "third party" as it is used in the passage related to

subrogation and reimbursement is clear and unambiguous. The Plan document clearly requires reimbursement by McCutchen of monies recovered including the UIM benefits paid by his insurance company. The Court finds that the interpretation on the Plan document was not arbitrary and capricious, and the Plan is, therefore, entitled to reimbursement from the monies McCutchen received in settlement of his tort claims including the uninsured motorist benefits received from his insurance company.³

Defendants further argue that: (1) Plaintiff is not entitled to recover because McCutchen was not fully compensated for his injuries; (2) any recovery by the Plaintiff must be reduced by the proportionate share of attorney fees; and (3) if Plaintiff is entitled to any recovery, such recovery is limited to the \$41,500.00 escrowed in RL&P's trust account.⁴

³ Similarly, in Sereboff, the beneficiaries were covered by a health insurance plan that contained an "Acts of Third Parties" provision, which required a beneficiary who received benefits under the plan for injuries caused by a third party to reimburse the fiduciary for those benefits from all recoveries from the third party. Sereboff v. Mid-Atlantic Medical Services, 547 U.S. at 359. The beneficiaries were injured in an automobile accident, and the plan paid the medical expenses. Id. at 360. The fiduciary asserted a lien on the anticipated proceeds from the beneficiaries' lawsuit against the third parties responsible for their injuries. Id. After the lawsuit was settled, the fiduciary sought reimbursement of medical expenses paid by the ERISA plan. Id. The Court determined that ERISA § 502(a)(3), 29 U.S.C.S. § 1132(a)(3), authorized recovery in these circumstances. Id. at 367-369.

⁴ The Defendants have also argued that US Airways has waived its right to reimbursement, that the "unclean hands" doctrine prevents its recovery, and that recovery must be reduced by the proportion of the amount recovered to the

B. The Make Whole Doctrine

Attorney Perry, McCutchen's counsel in the underlying personal injury case, opined that the claims of Mr. And Mrs. McCutchen had a combined value of between \$1 million and \$1.75 million. It is undisputed that the McCutchens' total recovery was limited to \$110,000.00. Defendants argue therefore, that allowing Plaintiff to recover any amount would not be appropriate equitable relief considering that the make whole doctrine is a part of the federal common law.

This argument has been rejected by the Third Circuit⁵ in Bill Gray Enters. v. Gourley, supra. In rejecting the application of the make whole doctrine, the court stated: "importing federal common law doctrines to ERISA plan interpretation is generally inappropriate, particularly when the terms of an ERISA plan are clear and unambiguous." Id. at 220 n. 13 (citing Bollman Hat Co. v. Root, 112 F.3d 113, 117 n.3 (3d Cir.), cert. denied, 522 U.S. 952 (1997); Ryan by Capria-Ryan v. Fed. Express Corp., 78 F.3d 123 (3d Cir. 1996)). Because the Plan in Bill Gray unambiguously required reimbursement with the proceeds from the defendant's uninsured motorist's benefits, the court declined to extend the make whole remedy. Id.

alleged value of McCutchen's personal injury claim. The Court finds such arguments to be without merit.

⁵ Defendants assert that Sixth Circuit law should govern this matter because McCutchen is a resident of Ohio. Such assertion, however, has no basis in law and is rejected by this Court.

This Court finds no reason to deviate from the established precedent of the Third Circuit. We have found the language of the Plan to be clear and unambiguous, requiring McCutchen "to reimburse the Plan for amounts paid for claims out of any monies recovered." Exhibit 1 to Shanahan Affidavit, p. 72 (emphasis added). The make whole doctrine, therefore, is inapplicable in the face the Plan's clear reference to "all rights of recovery" and to "any monies recovered" set forth in the subrogation clause of the ERISA Plan document.

C. Reduction of Recovery - Attorney Fees

Defendants argue that any recovery by the Plaintiff must be reduced by the proportionate share of attorney fees. The parties agree that the language of the US Airways plan is silent on the issue of attorney fees. Defendants contend that if US Airways wanted to exclude the deduction of attorney fees from its recovery/reimbursement, it could have do so.

A plan or agreement, however, need not specifically address attorney's fees in order to unambiguously require full reimbursement. See Bollman Hat Co. v. Root, 112 F.3d at 117; see also Ryan by Capria-Ryan v. Federal Express Corp., 78 F.3d at 127-128. The ERISA plan in Ryan required "100% reimbursement for any plan benefits paid." Ryan by Capria-Ryan v. Federal Express Corp., 78 F.3d at 125. The court held the language was unambiguous and required complete reimbursement of all benefits paid, without a deduction for attorney's fees. The court determined that, because the plan was clear, there was no unjust enrichment ⁶ or windfall for the employer by

⁶ The court rejected the unjust enrichment argument stating:

completely reimbursing it even though the plaintiff's own attorney had borne the burden and expense of obtaining the funds from the third-party. *Id.* at 127-28 (emphasis added).

In Bollman Hat, the ERISA plan mandated reimbursement "up to the amount of such benefits paid" of "any payments" made under the plan. Bollman Hat Co. v. Root, 112 F.3d at 114. The court held that there was "no distinction" between that language and the Ryan plan language; the subrogation clauses were "materially identical," and plaintiff had no right to deduct his attorney's fees from the amount due his employer under the plan. Id.

The subrogation provision in the Plan at issue explicitly states: "[i]f the Plan pays benefits for any claim you incur as the result of negligence, willful misconduct, or other actions of a third party, the Plan will be subrogated to all your rights of recovery." The Plan requires reimbursement "for amounts paid for claims out of any monies recovered." The Plan's use of modifying terms such as "pays benefits for any claim," "subrogated to all your rights of recovery" and "any monies recovered" are similar to the terms used in Bollman Hat, which mandated reimbursement "up to the amount of such benefits paid" of "any payments", and in Ryan,

[&]quot;Enrichment is not 'unjust" where it is allowed by the express terms of the . . . plan. . . . it would be inequitable to permit the Ryans to partake of the benefits of the Plan and then, after they had received a substantial settlement, invoke common law principles to establish a legal justification for their refusal to satisfy their end of the bargain." Ryan by Capria-Ryan v. Federal Express Corp., 78 F.3d at 127-128.

requiring "100% reimbursement." The US Airways Plan is unambiguous and requires reimbursement of any payments made by the Plan to the participant and clearly provides for subrogation to all of McCutchen's rights of recovery. Third Circuit precedent does not permit federal common law to override a subrogation provision in an ERISA-regulated plan. US Airways, therefore, is entitled to full reimbursement of benefits paid under the Plan without reduction for the proportionate share of attorneys' fees.

D. Recovery Limited to Amount Escrowed

Defendants argue that to maintain its equitable nature, US Airways' reimbursement claim must seek a specifically identifiable and non-dissipated fund, specifically the \$41,500.00 set aside in the RL&P trust account. US Airways contends that the "specifically identifiable" fund consists of the \$100,000.00 from the UIM Claim and the \$10,000.00 from the personal injury lawsuit. Any disbursement of the funds in derogation of the Plan, it argues, does not render the relief sought any less equitable.

The Supreme Court has delineated what forms of equitable restitution are available under § 502(a)(3), distinguishing permissible forms of equitable restitution such as employment of a constructive trust or of an equitable lien from forms of legal restitution. See Great-West Life & Annuity Ins, Co. v. Knudson, 534 U.S. 204, 213 (2002)). Specifically, the Court stated: "[A] plaintiff [may] seek restitution in equity, ordinarily in the form of a constructive trust or an equitable lien, where money or property identified as belonging in good conscience to the plaintiff [can] clearly be traced to particular funds or

property in the defendant's possession." Id. at 213. In Sereboff v. MidAtlantic Med. Servs., Inc., the Court characterized MidAtlantic's relief as equitable stating:

the "Acts of Third Parties" provision in the Sereboffs' plan specifically identified particular fund, distinct from the Sereboffs' general assets-"[alll recoveries from a third party (whether by lawsuit, settlement, or otherwise)"--and a particular share of that fund to which Mid Atlantic was entitled—"that portion of the total recovery which is due [Mid Atlantic] for benefits paid." [T]herefore, Mid Atlantic could rely on a "familiar rullel of equity" to collect for the medical bills it had paid on the Sereboffs' behalf. This rule allowed them to "follow" a portion of the recovery "into the [Sereboffs'] hands" "as soon as [the settlement fund] was identified," and impose on that portion a constructive trust or equitable lien.

Sereboff v. Mid Atl. Med. Servs., 547 U.S. at 364. Moreover, the Court held that there was no strict tracing requirement for equitable liens by agreement. Id. at 365. "What is required, however, is that the agreement specifically identify a particular fund — distinct from the defendant's general assets — and a particular share of that fund to which the plan was entitled. Gilchrest v. Unum Life Ins. Co. of Am., 255 F. App'x 38, 45 (6th Cir. 2007) (unpublished) (citing Sereboff v. Mid All. Med. Servs., 547 U.S. at 364).

Here, US Airways seeks the restoration of particular funds, the lawsuit settlement and UIM

benefits, as distinct from McCutchen's general assets, traceable to the Plan and subject to an equitable lien for the benefit of the Plan. Therefore, even if the monies paid to McCutcheon are not specifically traceable to McCutchen's current assets because of commingling or dissipation, such monies remain subject to the Plan's equitable lien. See e.g. Gutta v. Standard Select Trust Ins. Plans, 530 F.3d 614, 621 (7th Cir. 2008) (allowing a claim under "29 U.S.C. § 1132(a)(3) even if the benefits it paid [the beneficiaryl are not specifically traceable to [the beneficiary's current assets because of commingling or dissipation."); Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer. Poirot Wansbrough, 354 F.3d 348, 350, 362 (5th Cir. 2003) (allowing an ERISA plan to recover the settlement proceeds that the plan beneficiary's law firm had deposited into its trust account). US Airways, therefore, has a claim for equitable relief over the "specifically identifiable" fund consisting of the \$100,000.00 from the UIM Claim and the \$10,000.00 from the personal injury settlement.

V. CONCLUSION

Based on the foregoing, the Court will grant Plaintiff's motion for summary judgment finding that Plaintiff is entitled to an equitable lien by agreement or constructive trust over \$66,865.82, consisting of medical benefits paid to McCutchen by the US Airways, Inc. Employee Benefits Plan, out of funds McCutchen recovered from settlements relating to his January 24, 2007 automobile accident. An appropriate order follows.

35a
s/ David Stewart Cercone
David Stewart Cercone
United States District Judge

APPENDIX C

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA

US AIRWAYS, INC., in its capacity as
Fiduciary and Plan Administrator of the
US Airways, Inc. Employee Benefits Plan,
Plaintiff,

vs.
JAMES E. MCCUTCHEN and ROSEN,
LOUIK & PERRY, P.C.,
Defendants.

ORDER OF COURT

AND NOW, this 30th day of August, 2010, upon consideration of the Motions for Summary Judgment (Document No. 27) filed on behalf of US Airways, Inc., the response thereto, and the briefs and appendices filed in support thereof, pursuant to this Court's Memorandum Opinion filed herewith,

IT IS HEREBY ORDERED the motion for summary judgment is GRANTED. US Airways, Inc.

is entitled to an equitable lien by agreement or constructive trust over \$66,865.82, consisting of medical benefits paid to Defendant James E McCutchen by the US Airways, Inc. Employee Benefits Plan. Judgment is entered in favor of Plaintiff, US Airways, Inc., and against Defendants, James E. McCutchen and the law firm of Rosen, Louik and Perry, PC. The Clerk shall mark this case closed.

s/ David Stewart Cercone
David Stewart Cercone
United States District Judge

APPENDIX D

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA

)
US AIRWAYS, INC., in its capacity as)
Fiduciary and Plan Administrator of the)
US Airways, Inc. Employee Benefits Plan,)
)
Plaintiff,)
)
Vs.)
)
JAMES E. MCCUTCHEN and ROSEN,)
LOUIK & PERRY, P.C.,)
)
Defendants.)
)
)

ORDER OF COURT.

AND NOW, this 2nd day of September, 2010, pursuant to this Court's Memorandum Opinion and Order filed on August 30, 2010,

IT IS HEREBY ORDERED AND ADJUDGED that pursuant to Rule 58 of the Federal Rules of Civil Procedure judgment is entered against Defendants Rosen, Louik and Perry, PC and in favor of Plaintiff US Airways, Inc. in the amount of \$41,500.00, which

represents the amount held the law firm's trust account for any lien against Defendant James E. McCutchen found to be valid, and against Defendant James E. McCutchen in the amount of \$25,365.82 and in favor of Plaintiff US Airways, Inc. The total amount of \$66,865.82 is entered in favor of Plaintiff US Airways, Inc.

s/ David Stewart Cercone
David Stewart Cercone
United States District Judge

APPENDIX E

IN THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 10-3836

US AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the US Airways, Inc. Employee Benefits Plan

V.

JAMES E. MCCUTCHEN; ROSEN LOUIK & PERRY, P.C.,

Appellants.

On Appeal from the District Court for the Western District of Pennsylvania (No. 08-cv-01593) District Judge: Honorable David Stewart Cercone

SUR PETITION FOR REHEARING EN BANC

Before: McKEE, Chief Judge, SLOVITER,

SCIRICA, RENDELL, AMBRO, FUENTES, SMITH, FISHER, CHAGARES, JORDAN, HARDIMAN, GREENAWAY, JR., and VANASKIE, Circuit Judges

The Petition for Rehearing filed by the Appellee in the above-entitled matter, having been submitted to the judges who participated in the decision of this court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular service not having voted for rehearing, the Petition for Rehearing by the panel and the Court en banc, is hereby DENIED.

BY THE COURT,

s/Julio M. Fuentes
Circuit Judge

DATED: January 4, 2012

OPPOSITION BRIEF

In The Supreme Court of the United States

U.S. AIRWAYS, INC., IN ITS CAPACITY AS FIDUCIARY AND PLAN ADMINISTRATOR OF THE U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN,

Petitioner,

V.

JAMES MCCUTCHEN AND ROSEN LOUIK & PERRY, P.C.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTION PRESENTED

In Sereboff v. Mid Atl. Med. Services, Inc., 547 U.S. 356 (2006), this Court held that an ERISA fiduciary could bring an action to enforce a reimbursement provision contained within an employee benefit plan because the action constituted "equitable" relief within the meaning of Section 502(a)(3). Sereboff expressly declined to decide, however, how the term "appropriate" modifies the scope of that relief, because the issue had not been raised below. 547 U.S. at 368 n.2.

This Court has since clarified, however, that Section 502(a)(3) directs courts to "look[] to the law of equity" when exercising their "discretion" to fashion "appropriate" relief for claims brought pursuant to that provision. CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1880-81 (2011). The lower court here is the first – and only – appellate court in this country to decide the question left unanswered by Sereboff in light of this Court's guidance in CIGNA.

The question presented is this: Whether a seriously injured ERISA beneficiary who has recovered only a fraction of his damages from a third-party must reimburse his ERISA plan for 100% of his medical expenses simply because the plan language so provides, or whether the scope of the plan's relief must be measured according to "appropriate" limiting principles of equity, in accordance with the language of Section 502(a)(3).

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INTRODUCTION

Petitioner's arguments in support of review lack merit. The lower courts are not "irrevocably split" on the question presented; nor have "half the circuits weighed in" on the issue, as petitioner contends. Pet. 24. In reality, only three courts of appeals have ruled on claims for equitable reimbursement in the wake of Sereboff v. Mid Atlantic Med. Servs., Inc., 547 U.S. 356 (2006), and only one of these decisions - the ruling below - was issued after this Court clarified, in CIGNA Corp. v. Amara, 131 S. Ct. 1866 (2011), that claims brought under ERISA Section 502(a)(3) must be evaluated according to equitable principles, rather than by strict enforcement of contract terms. The lower court's ruling thus stands alone as the only federal court ruling in the country to consider the question presented in light of this Court's most recent teachings on the meaning of the statute at issue. This alone is reason enough to deny review.

Petitioner's argument that review is warranted because the lower court's approach "flies in the face of ... ERISA's expressed intent" is equally flawed. Pet. 3. Petitioner insists that the principal purpose of ERISA is to "protect contractually defined benefits," and that the lower court's ruling would "eviscerate" that purpose "by endanger[ing] employer-provided benefit plans." Pet. 2-3. As explained below, however, this Court has consistently held that the principal object of ERISA is to protect plan beneficiaries, not to enforce plan terms. The lower court's ruling effectuates that purpose by ensuring that ERISA

reimbursement actions do not yield "a windfall" for ERISA plans at beneficiaries' expense. If anything, it is petitioner's approach that would eviscerate ERISA by leaving respondent and others like him "with less than full payment for [their] emergency medical bills" — a result that, in the lower court's words, would "undermin[e] the entire purpose of the [ERISA] Plan." Pet App. 16a.

Petitioner's contention that the lower court's approach would wreak havor on the healthcare system by eliminating a "predictable set of liabilities" for ERISA plans is similarly baseless. Pet. 12. In requiring courts to fashion relief on a case-by-case basis according to equitable principles, the lower court adopted the same approach that courts apply in virtually every other setting in which equitable reimbursement claims are made. In fact, this Court has already adopted this approach in the Medicaid context, recognizing that "[a] rule of absolute priority" creates a risk of "preclud[ing] settlement in a large number of cases"; works dramatic inequities "to the recipient in others"; and is "absurd and fundamentally unjust." Ark. Dep't of Health and Human Servs. v. Ahlborn, 547 U.S. 268, 288 & n.19 (2006) (internal quotations omitted). In these other contexts, health insurance does not lay in ruin, and premiums have not spiked.

In short, petitioner's hyperbolic claims that the lower court's ruling would destroy the ERISA healthcare system, to the ultimate detriment of ERISA plans and beneficiaries alike, has no basis in reality, lacks any support in the record, and disserves the lower court's careful, narrowly tailored ruling and the plain language of Section 502(a)(3) itself. It is petitioner's contrary approach that would undermine the system by creating results both "absurd and fundamentally unjust." Ahlborn, 547 U.S. at 288 n.19 (internal quotations omitted). This Court should decline petitioner's invitation to disturb the lower court's well-reasoned decision based on self-serving policy arguments that do not withstand even the mildest form of scrutiny.

STATEMENT OF THE CASE

1. Respondent James McCutchen was grievously injured in a car accident when "a young driver lost control of her car, crossed the median of the road, and struck" Mr. McCutchen's vehicle. Pet. App. 3a. Mr. McCutchen survived only after emergency surgery, and subsequently endured extensive medical care. He is now functionally disabled and suffers from significant and chronic pain that cannot be treated with medication. Mr. McCutchen's ERISA-governed, self-funded employee health benefit plan, administered by U.S. Airways and governed by ERISA (the "Plan"), paid his medical expenses, in the amount of \$66,866.

Uncontroverted evidence established that Mr. McCutchen's and his wife's total damages from the accident were between \$1 million and \$1.75 million. Pet. App. 29a. In addition to past medical expenses of \$66,866, Mr. McCutchen suffered economic damages

for past lost wages, future lost wages and loss of earning capacity, and non-economic damages for pain and suffering, embarrassment and humiliation, loss of enjoyment of life, and disfigurement. Mrs. McCutchen suffered damages for loss of consortium. See Appendix Vol. III, A228-229, U.S. Airways v. McCutchen, 663 F.3d 671 (3d Cir. 2011) (No. 10-3836) (hereinafter "ER").

After the accident, Mr. McCutchen and his wife retained a law firm, Respondent Rosen Louik & Perry, P.C. ("RLP"), to represent them in a claim against the driver of the car that caused the accident. With the firm's help, the McCutchens also made a claim for underinsurance coverage from their own automobile policy, as the driver had only \$100,000 in liability coverage to compensate all four individuals injured in the accident. Pet. App. 3a.

Because the driver had limited insurance coverage, and because three other people were seriously injured or killed, the McCutchens settled with the other driver for \$10,000 and then settled their underinsurance claim for policy limits of \$100,000. Pet. App. 3a. The total amount that the McCutchens recovered was \$110,000, which compensated them for, at most, 11% of their total damages. Pet. App. 3a; 29a.

Around the time of these settlements, RLP was contacted by one of the largest third-party subrogation recovery companies in the country, Ingenix Subrogation Services. This company informed RLP that it had been hired to pursue a subrogation/reimbursement

claim against Mr. McCutchen on behalf of his employer, U.S. Airways. It requested all the information concerning the settlements Mr. McCutchen had entered into and asserted a lien on the entire amount of medical expenses paid by the U.S. Airways' Plan.

Because Mr. McCutchen's recovery was such a small fraction of his total damages, RLP asked Ingenix to waive its asserted lien. ER208. Ingenix refused, and demanded that it be reimbursed for 100% of the medical expenses based on the language of the Plan. RLP informed Ingenix that it would escrow \$41,500 in its trust account, which represented the asserted amount of the lien minus collection costs, until the dispute was resolved. ER218.

U.S. Airways then sued both Mr. McCutchen and RLP in the Western District of Pennsylvania, seeking "appropriate equitable relief" under Section 502(a)(3) of ERISA in the form of a constructive trust or equitable lien on the \$41,500 held in trust and the remaining \$25,366 personally from Mr. McCutchen. Pet. App. 4a. U.S. Airways based its claim for reimbursement on a provision in the Plan stating that a beneficiary is required to reimburse the Plan for any amounts it has paid out of any monies the beneficiary recovers from a third-party, without any contribution to attorneys' fees and expenses. Pet. App. 4a. U.S. Airways argued that the court was required to enforce the Plan language as written, notwithstanding Section 502(a)(3)'s reference to "appropriate equitable relief."

In response, Mr. McCutchen argued that it would be unfair and inequitable to reimburse U.S. Airways in full when he had only recovered for a small fraction of his injuries, including pain and suffering. Pet. App. 5a. He argued that U.S. Airways, which made no contribution to his attorneys' fees and expenses, would be unjustly enriched if it were now permitted to recover from him without any allowance for those costs. Pet. App. 5a.

- 2. The district court granted U.S. Airways' request for 100% reimbursement on the ground that it was duty-bound, under "established precedent of the Third Circuit" decided prior to Sereboff, to apply rules of contract law in measuring the award. Pet. App. 30a. Based on that pre-Sereboff precedent, the district court required Mr. McCutchen to sign over the \$41,500 held in trust and to pay \$25,366 from his own pocket. Pet. App. 34a.
- 3. A unanimous panel of the Third Circuit reversed. The court of appeals first observed that, in Sereboff, this Court held that an ERISA plan administrator's claim for reimbursement arises under, and is governed by, Section 502(a)(3) of ERISA. The lower court further observed that Sereboff "expressly reserved decision on whether the term 'appropriate,' which modifies 'equitable relief' in § 502(a)(3), would make equitable principles and defenses applicable to a claim under that section." Pet. App. 9a (citing Sereboff, 547 U.S. at 368 n.2).

"This case," the Third Circuit went on to explain, "squarely presents the question that Sereboff left open: whether § 502(a)(3)'s requirement that equitable relief be 'appropriate' means that a fiduciary like U.S. Airways is limited in its recovery from a beneficiary like McCutchen by the equitable defenses and principles that were 'typically available in equity.'" Pet. App. 9a. The court concluded that the answer is "yes," holding that phrase "appropriate equitable relief" means "more than just that the relief [an ERISA Plan] seeks must be of an equitable type; court must also exercise their discretion to limit that relief to what is 'appropriate' under traditional equitable principles." Pet. App. 9a. "In particular," the lower court found, because U.S. Airways' claim was for equitable reimbursement, the equitable principle of "unjust enrichment frames U.S. Airways' claim." Pet. App. 9a.1

In reaching this conclusion, the lower court followed the roadmap set out by this Court's trilogy of Section 502(a)(3) cases — Mertens v. Hewitt Assocs., 508 U.S. 248 (1993), Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002), and Sereboff — to determine whether the measure of relief sought by the Plan was "appropriate" in light of the "equitable principles and defenses that were typically applied."

The lower court also explained that the question of whether some version of the "make-whole" doctrine applied here, as a matter of federal or state common law, was not at issue in the case, and so expressly declined to address it. See Pet. App. 9a.

Pet. App. 10a-12a. In each case, this Court instructed lower courts to consult treatises on equity when interpreting Section 502(a)(3). See Mertens, 508 U.S. at 255-56; Knudson, 534 U.S. at 217; Sereboff, 547 U.S. at 368. In keeping with this trilogy, the lower court consulted the same treatises cited by this Court "to determine whether [the] equitable relief [sought by the Plan] is 'appropriate.'" Pet. App. 11a. The lower court found that "[t]hese sources all support [the]... position that the principle of unjust enrichment is broadly applicable to claims for equitable relief." Pet. App. 11a.

In so ruling, the lower court held that its prior decisions interpreting claims for reimbursement were no longer good law in light of this Court's rulings in Knudson and Sereboff. Pet. App. 12a. In particular, the lower court explained that its earlier decisions erred by framing the question as "whether federal common law can override the express language of benefit plans." Pet. App. 13a-14a. This view, the lower court concluded, is no longer valid in the face of Sereboff's holding, and Knudson's teaching, that reimbursement claims are subject to Section 502(a)(3), not "federal common law." Pet. App. 12a. And under this framework, the lower court explained, reimbursement claims under Section 502(a)(3) are subject to, and limited by, the application of relevant "equitable defenses and principles that were typically available in equity." Pet. App. 11a.

The lower court also faulted the two contrary post-Sereboff decisions of its sister courts, Zurich

Amer. Ins. Co. v. O'Hara, 604 F.3d 1232 (11th Cir. 2010) and Admin. Comm. of Wal-Mart Stores, Inc. Assocs.' Health and Welfare Plan v. Shank, 500 F.3d 834 (8th Cir. 2007), for adopting the same (since rejected) approach taken by the Third Circuit's pre-Sereboff cases. The lower court explained that, "[1]ike our pre-Sereboff decisions, these cases frame the question of whether equitable principles limit the scope of an administrator's right to reimbursement as a question of whether federal common law can override the Plan's controlling language." Pet. App. 13a. Sereboff rejected this approach, the Third Circuit noted, instead holding that, under Section 502(a)(3), a court's role is to ask "whether the relief sought in the action is 'appropriate' under traditional equitable principles and doctrines." Pet. App. 14a.

The lower court also took issue with these courts' unilateral adherence to strictly enforcing plan language. Pointing to this Court's recent decision in CIGNA Corp. v. Amara, 131 S. Ct. 1866 (2011), the lower court explained that "the importance of the written benefit plan is not inviolable, but is subject – based upon equitable doctrines and principles – to modification and, indeed, even equitable reformation under § 502(a)(3)." Pet. App. 15a.

The Third Circuit further rejected U.S. Airways' "practical concern that the application of equitable principles will increase plan costs and premiums." Pet. App. 16a. The court noted that "[t]his concern does not address the statutory language and is, in

any event, unsubstantiated by the circumstances of this case." Pet. App. 16a. The lower court concluded that "U.S. Airways cannot plausibly claim it charged lower premiums because it anticipated a windfall." Pet. App. 16a.

4. Against this backdrop, the lower court applied the governing equitable principle of "unjust enrichment" to conclude that the judgment requiring Mr. McCutchen to provide full reimbursement to U.S. Airways "constitutes 'inappropriate' and 'inequitable' relief." Pet. App. 16a. The court noted that, "[b]ecause the amount of the judgment exceeds the net amount of McCutchen's third-party recovery, [the judgment] leaves him with less than full payment for his emergency medical bills, thus undermining the entire purpose of the Plan." Pet. App. 16a. "At the same time," the lower court found, awarding full reimbursement to the Plan "would amount to a windfall for U.S. Airways, which did not exercise its subrogation rights or contribute to the cost of obtaining the third-party recovery." Pet. App. 16a. Concluding that "[e]quity abhors a windfall," Pet. App. 16a, the lower court vacated the district court's final judgment granting full reimbursement to U.S. Airways.

The lower court ultimately declined to decide, however, "what would constitute appropriate relief," on the ground that "equity calls for full factual findings rather than our speculation..." Pet. App. 17a. Instead, the court of appeals remanded the case to the district court to "exercise its discretion under

§ 502(a)(3)" to fashion appropriate equitable relief. Pet. App. 17a.

REASONS FOR DENYING REVIEW

I. REVIEW SHOULD BE DENIED TO ALLOW FURTHER PERCOLATION AMONG THE LOWER COURTS ON THE QUESTION PRESENTED.

Petitioner's principal basis for seeking review that the lower court's ruling conflicts with "[f]ive other circuits" - is incorrect. See Pet. 12. Of petitioner's five-circuit tally, two were decided pre-Sereboff this Court's seminal decision holding that ERISA reimbursement claims are "equitable" within the meaning of Section 502(a)(3). Those cases merely addressed the issue that was asked and answered in Sereboff, and never even reached the question presented here, which is whether the word "appropriate" in Section 502(a)(3) limits the amount of relief available pursuant to an ERISA reimbursement provision. Petitioner's remaining three cases were decided post-Sereboff, yet focused on an entirely different set of issues - i.e., whether "federal common law" limits an ERISA Plan's claim for reimbursement - and thus similarly did not reach the question presented here. None of these cases had the benefit of this Court's teaching in CIGNA, which the lower court here found highly relevant to its decision. Finally, the question presented in this case is now pending in at least one additional court of appeal, with several more courts

slated to address it in the coming months. Given this landscape, further percolation among the lower courts is warranted before this Court weighs in on the issue.

A. Petitioner Overstates the Extent of a Split Among the Lower Courts on the Question Presented.

1. To begin, two of the five decisions cited by petitioner – Bombardier Aerospace Emp. Welfare Benefits Plan v. Ferrer, Poirot, & Wansbrough, 354 F.3d 348 (5th Cir. 2003), and Admin. Comm. of Wal-Mart Stores v. Varco, 338 F.3d 680 (7th Cir. 2003) – did not even reach the question presented in this case. Instead, they solely addressed the predicate question that this Court resolved in Sereboff: whether a claim for reimbursement is "equitable," and therefore authorized at all, under Section 502(a)(3).²

This question has no relevance to this case. Prior to Sereboff, the lower courts were split on the threshold question of whether an ERISA Plan could even seek equitable reimbursement from an injured beneficiary. Bombardier and Varco formed one side of this

² See Bombardier, 354 F.3d at 355 (deciding whether the "Plan's suit is essentially legal in nature" or whether "it seeks relief that indeed is equitable in nature and thus authorized by § 502(a)(3)"); Varco, 338 F.3d at 687 (determining whether a Plan's restitution claim was "equitable under § 502(a)(3)," or whether it was "essentially a legal claim . . . to enforce its contract rights under the Plan").

split. Other courts had reached the opposite conclusion. Sereboff ultimately put this issue to rest, siding with Bombadier and Varco in holding that: (a) ERISA reimbursement claims are governed by Section 502(a)(3); and (b) such claims constitute "equitable relief" within the meaning of that statute. 547 U.S. at 369.

But Sereboff expressly declined to consider the essential next question, which is whether the word "appropriate" in Section 502(a)(3) modifies the amount of relief available to an ERISA plan for an equitable claim of reimbursement. See id. at 368 n.2. In other words, Sereboff did not decide whether courts must enforce reimbursement provisions as written, or whether

See Bombardier, 354 F.3d at 355 ("[W]e hold the Plan's requested relief ... to be equitable in nature. Accordingly, we further hold that § 502(a)(3) authorizes the Plan's claim for relief."); Varco, 338 F.3d at 688 ("[T]he reimbursement action by the Committee in this unique case is equitable because the funds ... are identifiable, are in the control of a defendant, and the Committee is rightfully entitled to the monies under the terms of the Plan. Because those elements are met here, the Committee's claim is equitable under § 502(a)(3)(B) of ERISA...").

^{*} See, e.g., Qualchoice, Inc. v. Rowland, 367 F.3d 638 (6th Cir. 2004) (holding that Section 502(a)(3) does not authorize a Plan's action for reimbursement).

[°] Specifically, the Court said "[n]either the District Court nor the Court of Appeals considered the argument that Mid Atlantic's claim was not 'appropriate' apart from the contention that it was not 'equitable,' and from our examination of the record it does not appear that the Sereboffs raised this distinct assertion below. We decline to consider it for the first time here." Sereboff, 547 U.S. at 368 n.2 (emphasis added).

a court's job is to apply principles of equity to determine just how much relief is "appropriate" under the particular circumstances of a given case. It is that latter question that was decided by the lower court in this case. That question, however, was never addressed by *Varco* or *Bombadier*. Thus neither decision is pertinent to the question presented here.

Petitioner nonetheless strains to manufacture a split by noting that Bombardier and Varco ultimately awarded the ERISA Plans 100% reimbursement based on the language of the Plan. See Pet. 14-15. This result is no different from the scores of pre-Sereboff cases that ruled, without the benefit of Sereboff's guidance, in favor of ERISA Plans seeking reimbursement. See, e.g., Harris v. Harvard Pilgrim Health Care, Inc., 208 F.3d 274 (1st Cir. 2000); United McGill Corp. v. Stinnett, 154 F.3d 168 (4th Cir. 1998); Ryan by Capria-Ryan v. Fed. Express Corp., 78 F.3d 123 (3d Cir. 1996). In those courts' view, the proper scope of relief was whatever the Plan said it was, but petitioner makes no suggestion that those pre-Sereboff cases now contribute to the split, even though they employed the same analysis.

More to the point, though, these courts all awarded full relief without first deciding how – or even whether – the word "appropriate" modifies the measure of relief that may be afforded under Section 502(a)(3). That they did not decide this question is understandable – they did not know to ask, let alone answer, this question because it was not until Sereboff that this Court flagged it as relevant. Instead,

these courts (including Bombardier and Varco) simply asked whether the plan language unambiguously entitled the Plan to relief and then, in the event that it did, they enforced that language. Sereboff, however, definitively reframed the analysis, by holding that claims for reimbursement, to the extent that they are allowed, are expressly governed by Section 502(a)(3) itself, which contains the all-important reference to both "appropriate" and "equitable" relief. See Sereboff. 547 U.S. at 369. That these pre-Sereboff courts saw fit to award 100% reimbursement has no bearing here because those awards were based on an analysis that failed to construe both key terms in the statute. Thus the different result between these cases, on the one hand, and the lower court's ruling, on the other, regarding the proper measure of relief to be awarded to an ERISA plan does not create, or even contribute to, any split among the circuits on the question presented here.

2. None of the three post-Sereboff decisions cited by petitioner provides any more convincing basis for this Court's review. Like the pre-Sereboff cases cited above, none of those cases meaningfully addressed how the word "appropriate" modifies the availability and scope of relief under Section 502(a)(3). Instead, they looked only to whether federal common law could modify or override clear Plan language. As a result, every one of these decisions side-stepped the question presented here.

For instance, only two questions were presented to the court in Moore v. Capitalcare, Inc., 461 F.3d 1

(D.C. Cir. 2006): (1) whether the Plan's "subrogation claim is legal, not equitable, and therefore barred by ERISA"; and (2) whether the Plan was "not entitled to reimbursement because [the beneficiary] was not 'made whole' by her settlement." Id. at 6. Everyone agreed that the first question was settled by this Court in Sereboff, see id. at 8, and so the court was left to address the "only remaining challenge" to the subrogation claim: whether, "as a matter of federal common law," the make-whole doctrine applied to defeat a Plan's claim for reimbursement. Id. at 8. Moore has no bearing here because the lower court never considered whether the "make-whole" rule applies as a matter of federal (or state) common law. See Pet. App. 9a n.2 ("McCutchen does not pursue this argument on appeal, and we do not address it."). Instead, the lower court - as instructed by this Court in its (now quadrilogy of) ERISA Section 502(a)(3) cases consulted equitable treatises to determine whether the equitable relief sought by an ERISA Plan is "appropriate" within the meaning of Section 502(a)(3). Pet. App. 11a.

Like Moore before them, petitioner's last two cases, Admin. Comm. of Wal-Mart Stores, Inc. Assocs.' Health and Welfare Plan v. Shank, 500 F.3d 834 (8th Cir. 2007), and Zurich Amer. Ins. Co. v. O'Hara, 604 F.3d 1232 (11th Cir. 2010), merely held that federal common law does not limit the measure of relief under a Section 502(a)(3) claim for equitable reimbursement. See Shank, 500 F.3d at 839 ("federal courts lack authority to fashion a rule of federal common law that conflicts with the written plan

and that is unnecessary to achieve the purposes of ERISA") (emphasis added); O'Hara, 604 F.3d at 1237 (refusing to "[a]pply[] federal common law to override the Plan's controlling language") (emphasis added).⁶

This conclusion, however, similarly side-steps the question presented here, which is whether the statute itself, as opposed to federal common law, requires a court to apply equitable limitations on a claim for reimbursement under Section 502(a)(3). In the days before Sereboff, many courts applied federal common law in ERISA cases "when necessary to effectuate the purposes of ERISA," but not "when its application would conflict with the statutory provisions of ERISA, discourage employers from implementing plans governed by ERISA, or threaten to override the explicit terms of an established ERISA benefit plan." Singer v. Black & Decker Corp., 964 F.2d 1449, 1452 (4th Cir. 1992). For reimbursement claims, this rule allowed federal common law to override a Plan's reimbursement provisions "only in the absence of controlling plan language." Varco, 338 F.3d at 692; see Ryan, 78 F.3d at 127-28.

But whatever the merits of that question, it is a categorically different one from that addressed by the lower court here. In keeping with Sereboff, the lower

⁶ Although these courts said that "full recovery according to the terms of the plan is not 'appropriate' relief within the meaning of ERISA," Shank, 500 F.3d at 837, they reached this conclusion only by asking whether federal common law doctrines could override plan language. See id.

court declined to consider whether federal common law doctrines could limit the availability of relief, focusing instead on the limitations embedded in the statute itself. See Pet. App. 9a. Thus the "disagree[ment]" between the lower court here and the Shank and O'Hara courts is only whether courts should apply "federal common law" to ERISA reimbursement claims or, as Sereboff instructed, courts should apply limiting principles of equity to determine how much relief is "appropriate" in a given case. Indeed, the lower court itself observed as much. See Pet App. 13A (noting that both O'Hara and Shank focused on "whether federal common law can override the express language of benefit plans," rather than determining whether, under Section 502(a)(3) itself, "the relief sought in the action is 'appropriate' under traditional equitable principles."). The fact remains, therefore, that neither Shank nor O'Hara even reached the precise question presented here, which is whether the word "appropriate" in Section 502(a)(3) modifies the scope of an ERISA plan's reimbursement claim under governing principles of equity.

B. CIGNA Bears Directly on the Question Presented, and There is No Post-CIGNA Split of Authority Worthy of This Court's Review.

Moreover, none of the cases cited by petitioner as creating a split, including the two most recent cases – Shank and O'Hara – provides a basis for this Court's review because they were all decided before this

Court's decision in CIGNA, which directly informed the approach taken by the lower court. See Pet. 18 (acknowledging that the lower court "purported to find authority for its approach from this Court's decision in CIGNA"); see also Pet. App. 15a-16a (lower court's discussion of CIGNA's relevance to question presented). This fact alone reveals the absence of any split worthy of this Court's review, let alone a "direct" one. Pet. 11.7

CIGNA held that "Section 502(a)(3) invokes the equitable powers of the District Court" and expects that courts will "exercise [their] discretion" to impose "appropriate" remedies for claims brought under Section 502(a)(3). 131 S. Ct. at 1880. CIGNA went on to explain that, as part of a district court's discretionary exercise of its equitable powers, the court must limit the availability of relief to those "traditionally considered equitable remedies," and must also look to equitable treatises when fashioning "appropriate" relief. Id. at 1879.

Petitioner cites to a lone post-CIGNA district court decision as evidence that the "lower courts, too, appear to be recognizing the new divide between the circuits." Pet. 15 (citing Schwade v. Total Plastics, Inc., 2011 WL 5459649 (M.D. Fla. Nov. 10, 2011)). The Schwade court's discussion of the decision below was dicta, however, and arose on a motion to reconsider a ruling on an unrelated issue, and thus lacked the benefit of full briefing. In any event, this Court is not in the habit of granting certiorari to resolve conflicts between a court of appeals and the unreviewed decisions of district courts in other circuits.

The core teaching of CIGNA is that the equitable treatises cited in Sereboff, Knudson, and Mertens are relevant not just for determining the type of appropriate remedy (and whether it was traditionally equitable or not), but also for identifying the principles governing the award of any relief afforded by the remedy. See id. at 1880. In particular, CIGNA cited to treatises on equity to support the conclusion that "[e]quity courts possessed the power to provide relief in the form of monetary 'compensation' . . . to prevent [a defendant's] unjust enrichment." Id. (emphasis added). This ruling directly supports respondents' core theory in the lower court, which was that petitioner's claim for reimbursement should be measured according to the equitable principle of unjust enrichment. The Third Circuit embraced CIGNA's teaching in adopting that principle in its decision. Pet. App. 11a (citing CIGNA for the proposition that the "animating principle" of unjust enrichment "clearly applies to a trustee's claim for reimbursement from its beneficiary").

CIGNA is also directly relevant to the question presented here because it made clear that, under Section 502(a)(3), a court sitting in equity is not obligated to categorically enforce an ERISA Plan's terms as written – a conclusion that contradicts petitioner's core argument, and undermines the rulings in several of petitioner's cases. See Pet. 12 (contending that courts may not override contractual language when faced with a Section 502(a)(3) claim). In particular, CIGNA held that "[t]he power to reform contracts

(as contrasted with the power to enforce contracts as written) is a traditional power of an equity court, not a court of law." 131 S. Ct. at 1879 (emphasis added). CIGNA thus stands firmly for the principle that a court sitting in equity should not enforce a contract as written where equity demands otherwise. And, for claims arising under Section 502(a)(3), this principle authorizes a court to apply appropriate equitable principles to determine the amount of reimbursement to which a plan is entitled.

CIGNA's lessons for how courts should approach and resolve claims for equitable reimbursement have only been addressed by one court in the entire country - the lower court here. As the lower court explained, CIGNA demonstrates that "the importance of the written benefit plan is not inviolable, but is subject - based upon equitable doctrines and principles - to modification and, indeed, even equitable reformation under § 502(a)(3)." Pet. App. 15a. In reaching this conclusion, the lower court acknowledged (as petitioner notes) that the facts and particular claims in CIGNA were different than those here. but the court observed that CIGNA stands for a broader proposition for courts considering any claim under Section 502(a)(3): "when courts were sitting in equity in the days of the divided bench (or even when they apply equitable principles today) contractual language was not as sacrosanct as it is normally considered to be when applying breach of contract principles at common law." Pet. App. 15a. This principle led the lower court to conclude that, because

Section 502(a)(3) "invokes the equitable powers of the District Court," any relief is subject to appropriate equitable principles even if that means contractual language is given something less than full effect. Pet. App. 15a ("[A]s demonstrated by the language of § 502(a)(3) and now CIGNA, Congress . . . limit[ed] fiduciaries to 'appropriate equitable relief,' thus invoking principles that it surely knew are sometimes less deferential to absolute freedom of contract.").

In light of the foregoing, petitioner's invitation to this Court is premature. There is no dispute that the lower court grounded its decision on the lessons set forth in CIGNA. There is also no dispute that the lower court is the only court of appeals to address CIGNA's impact on claims for equitable reimbursement under Section 502(a)(3). Petitioner's claim that the Third Circuit misapplied CIGNA misses the point. That the lower court found CIGNA relevant and persuasive is reason enough to allow other courts to consider the issue. Indeed, this identical issue is pending in the Ninth Circuit, see CGI Techs., Inc. v. Rose, Nos. 11-35127; 11-35128 (9th Cir. argued Feb. 9, 2012), and several other cases are pending in district courts in other circuits as well. See, e.g., Cent. States, Se. and Sw. Areas Health and Welfare Fund v. Lewis, No. 11-4845, 2012 WL 1719189 (N.D. Ill. May 15, 2012); Unum Life Insurance Co. of Amer. v. Norton, No. 10-0050, 2012 WL 360179 (N.D. Ga. Feb. 2, 2012). These courts should be allowed an opportunity to decide the issue in the first instance. If all subsequent courts agree with the lower court's reading of CIGNA,

then O'Hara and Shank will become vulnerable to reversal within their own circuits. There is no reason for this Court to step in now, given that the post-Sereboff split may disappear on its own.

II. THE THIRD CIRCUIT'S RULING IS CON-SISTENT WITH THIS COURT'S PRIOR RULINGS AND IS CORRECT.

Review is also unwarranted because the lower court's ruling is consistent with the plain language of Section 502(a)(3) and with this Court's prior teachings on Section 502(a)(3). Petitioner's contrary argument hinges on the perplexing proposition that the words "appropriate equitable relief" require courts to categorically enforce contract language. In petitioner's view, a court must enforce the plan document as written when fashioning relief under Section 502(a)(3) and may not exercise any discretion when determining the measure of reimbursement. This approach, however, reads the words "appropriate equitable relief" right out of the statute. If petitioner were correct, then Congress would have conferred upon courts the right to grant a legal remedy, which is exactly what is being sought by petitioner in this case. But Congress did no such thing. Instead, it directed courts to award "appropriate equitable relief" - language that even a first year law student knows is very different from a straightforward legal remedy. Try as it might, petitioner cannot reconcile its enforce-the-contract theory with the words Congress wrote when it enacted Section 502(a)(3).

The Third Circuit's application of equitable principles also reflects a proper reading of this Court's consistent prior teachings that Congress's use of the word "appropriate" in Section 502(a)(3) is a term of limitation, restraining the availability of relief based upon traditional equitable principles. Varity Corp. v. Howe, 516 U.S. 489, 515 (1996) (holding that equitable relief under the statute is not automatic, but instead must be "fashion[ed]" and may be refused where "appropriate"); see also CIGNA, 131 S. Ct. at 1880 (holding that "Section 502(a)(3) invokes the equitable powers of the District Court" and remanding to allow the lower court to decide whether it is "appropriate to exercise its discretion under §502(a)(3) to impose [a] remedy"); Knudson, 534 U.S. at 211 n.1 (holding that ERISA 502(a)(3) "contain[s] the limitations upon its availability that equity typically imposes"); Harris Trust & Sav. Bank v. Solomon Smith Barney, Inc., 530 U.S. 238, 252 (2000) (interpreting ERISA Section 502(a)(3) "to incorporate common-law remedial principles").

The lower court's ruling is also consistent with this Court's further instructions that, when Congress uses the term "appropriate" in connection with an equitable remedy, a court has "broad discretion" to "fashion[] discretionary equitable relief" through the careful consideration of relevant equitable factors. Florence Cnty. Sch. Dist. v. Carter, 510 U.S. 7, 16 (1993) (internal quotations omitted). This instruction embodies the fundamental principle that a district court, when sitting in equity, is a "court of conscience"

that enjoys broad discretion to afford a measure of equitable relief where equity and justice demand. Wilson v. Wall, 73 U.S. (6 Wall.) 83, 90 (1867).

A district court's task, then, when faced with an equitable reimbursement claim under Section 502(a)(3), is to balance all the relevant equitable factors and award only that relief that is "appropriate" in equity. Here, that is precisely what the lower court held. It opined that "the phrase 'appropriate equitable relief' means more than just that the relief must be of an equitable type; courts must also exercise their discretion to limit that relief to what is 'appropriate' under traditional equitable principles." Pet. App. 9a.

This Court's precedents reveal the folly of petitioner's contrary position that a court is prohibited from doing anything other than categorically enforcing plan language. In Sereboff, for example, the Court held that, when determining the "scope of remedial power conferred on district courts" by Section 502(a)(3), courts must be guided by the law as it stood during "the days of the divided bench." 547 U.S. at 361-62; see also Knudson, 534 U.S. at 217 (applying equitable principles to interpret and apply Section 502(a)(3)); CIGNA, 131 S. Ct. at 1881 (same). Nowhere has this Court held – or even suggested – that Congress intended for courts to apply legal rules when determining the proper amount of relief under Section 502(a)(3).

Petitioner nonetheless argues that, because the statute authorizes appropriate equitable relief only "for the purpose of redressing any violations or enforcing any provisions of ERISA or an ERISA plan," Pet. 16 (alterations omitted), a court must enforce plan reimbursement language as written in order to "protect contractually defined benefits." Pet. 17. As the lower court held, the most basic problem with this argument is that it violates the plain language of Section 502(a)(3). Pet. App. 10a-11a. If a court's job were merely to "enforce plan terms," then there would have been no need for Congress to limit a court's role to granting "appropriate equitable relief," as it did in Section 502(a)(3).

If there were any doubt on this point, it would be dispelled by the fact that Congress included just such a contractually-based enforcement provision in a different part of Section 502 - Section 502(a)(1)(B) that affirmatively authorizes a plaintiff to "enforce his rights under the terms of a plan." Pet. App. 6a-7a. As the lower court observed, Congress intentionally excluded fiduciaries (like petitioner) from pursuing relief under this provision. Pet. App. 7a (explaining that Congress limited the availability of this relief to participants and beneficiaries). Petitioner wants this form of relief imported into Section 502(a)(3). But a court cannot, as petitioner would have it, adopt a reading of that provision that would render its key limitation null and void. Nw. Forest Res. Council v. Glickman, 82 F.3d 825, 833-34 (9th Cir. 1996) ("[A] statute must be interpreted to give significance to all of its parts. We have long followed the principle that

'[s]tatutes should not be construed to make surplusage of any provision.'") (citation omitted).

In the final analysis, petitioner's insistence that courts must categorically enforce plan terms based on the language of Section 502(a)(3) reflects an effort to substitute one remedy for another. This Court has emphasized that Section 502(a)(3)'s reference to "appropriate equitable relief" is the key animating language of the statute, and "requires" that a court "recognize the difference between legal and equitable forms of restitution." Knudson, 534 U.S. at 218. The lower court correctly recognized and applied the principle that, when a party, like petitioner, seeks an equitable remedy for restitution, it is necessarily limited to a measure of relief consistent with the equitable principles governing its claim for relief. Any other interpretation "would limit the availability of relief not at all" and render the modifier "appropriate' superfluous." Id.

III. THE LOWER COURT'S APPROACH IS CONSISTENT WITH ERISA'S CORE PURPOSES AND REPRESENTS SOUND PUBLIC POLICY.

A. ERISA's Central Purpose is to Protect Beneficiaries, Not Plans.

Nor is review warranted on the ground that the ruling below conflicts with ERISA's "primary" purpose of ensuring that plan terms are strictly enforced in order to create uniformity and foster certainty. Pet. 17. In reality, this Court has consistently held that "[t]he principal object of [ERISA] is to protect plan participants and beneficiaries," not to enforce plan terms. Boggs v. Boggs, 520 U.S. 833, 845 (1997); see also Varity, 516 U.S. 489, 513 (1996) (holding that ERISA's ultimate purpose is "to protect the interests of participants and beneficiaries") (quoting from ERISA's basic purposes provision) (alterations omitted).

That is why, in case after case, this Court has said that the strict enforcement of plan terms is, at most, a subsidiary purpose. See Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 114 (2008) (finding that the desire to protect participants and beneficiaries "outweighed" other subsidiary purposes, including the freedom of employers to set up their benefit plans); Varity, 516 U.S. at 513 (holding that ERISA's "basic purposes" of "protect[ing] the interests of participants and beneficiaries" trump other "subsidiary congressional purpose[s]").

In short, the primary purpose of ERISA is to protect people – participants and beneficiaries – not plans. The "principle" of rigid adherence to plan terms must yield when it comes up against a specific statutory provision of ERISA that imposes specific limitations on the strict enforcement of plan terms. This is because, as this Court has said, and as the lower court correctly recognized, the purpose of "enforc[ing] the terms of the plan" is "inadequate to overcome the words of [ERISA's] text regarding the

specific issue under consideration." Pet. App. 16a (quoting Knudson, 534 U.S. at 220).

Indeed, even the cases petitioner cites agree that the strict enforcement of plan terms must yield in the face of some specific statutory policy to the contrary. For example, in Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73 (1995), this Court merely held that an employer's amendment of its plan was justified because it was consistent with the requirements set forth in the text of ERISA, specifically Section 402(b)(3). See id. at 79-80. As this Court recognized two years later, however, the right that an employer or plan sponsor may have to "unilaterally amend or eliminate" its welfare benefit plan "does not justify" a departure from the plain language of ERISA. Inter-Modal Rail Emps. Ass'n v. Atchison, Topeka and Santa Fe Ry. Co., 520 U.S. 510, 515 (1997).

Section 502(a)(3), by its plain terms, overrides any policy that may exist requiring the strict enforcement of plan terms. Time and again, this Court has made clear that this provision "invokes the equitable powers of the District Court," CIGNA, 131 S. Ct. at 188, "incorporate[s] common-law remedial principles," Harris Trust, 530 U.S. at 252, and "contain[s] the limitations upon its availability that equity typically imposes." Knudson, 534 U.S. at 211 n.1. These limiting principles are "explicit" in the words "appropriate equitable relief," Harris Trust, 530 U.S. at 250, and therefore trump plan language that would seek to override them. As the lower court recognized, any

other result would be directly contrary to ERISA's primary purpose of protecting participants, not plans.

B. The Decision Below Would Not Ultimately Harm Beneficiaries by Increasing Plan Costs and Premiums.

Petitioner makes no further headway by arguing, in response, that permitting ERISA plans to recover whatever relief they write into their plans would actually vindicate ERISA's objective of protecting beneficiaries by reducing their costs in the form of premium payments. See Pet. 21-22 (claiming that the lower court's approach would "reduce[] health care benefits," increase "out-of-pocket costs for participants," and eliminate health care coverage for thousands of individuals). Even if this were true as a factual matter (and, to be clear, it is not), it would be irrelevant; the statutory language is clear, and courts cannot override a statutory command based on speculative concerns that Congress may have struck an unwise balance. Knudson, 534 U.S. at 217 ("It is. however, not our job to find reasons for what Congress has plainly done; and it is our job to avoid rendering what Congress has plainly done (here, limit the available relief) devoid of reason and effect.").

But even if petitioner's policy arguments were relevant here, they lack any support in the record. At no point in this case did petitioner offer any actual evidence to support its theory that reimbursement leads to reduced premiums and overall lower health costs. All the lower court did was to recognize as much. See Pet. App. 16a (rejecting petitioner's argument that an equitable approach to measuring ERISA reimbursement claims "will increase plan costs and premiums" on the ground that it was "unsubstantiated by the circumstances of this case"). Petitioner's failure to even attempt to prove its case on this point is not surprising, because available evidence suggests that subrogation and reimbursement do not lead to any reduction in premium costs.⁸

Indeed, if petitioner's sky-is-falling rhetoric about the perils of the lower court's decision were true, one would expect to see reduced benefits and higher premiums in those contexts in which courts routinely apply an equitable approach to reimbursement claims. But petitioner has not supplied any evidence that this has occurred. This, too, is not surprising, because available evidence suggests that premiums are generally consistent across industries and contexts.

See, e.g., Brendan S. Maher & Radha A. Pathak, Understanding and Problematizing Contractual Tort Subrogation, 40 Loy. U. Chi. L.J. 49, 58 n.31 (2008) (concluding that "insurers will not offer lower subrogation adjusted rates even though they will grant themselves a subrogation right"); Johnny C. Parker, The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation, 70 Mo. L. Rev. 723, 737 (2005) ("[S]ubrogation has not led to lower premium costs for the insured."); see also Andrew H. Koslow, "Appropriate Equitable Relief" in Wal-Mart v. Shank: Justice for Whom?, 12 Quinnipiac Health L.J. 277, 279 (2009) (same); Roger M. Baron, Subrogation: A Pandora's Box Awaiting Closure, 41 S.D. L. Rev. 237, 243-45 (1996) (same).

See, e.g., Employer Health Benefits: Annual Survey, Kaiser Family Found. & Health Research & Educ. Trust (1999-2011).9

In short, petitioner's contention that the lower court's approach will actually harm beneficiaries lacks any support in the record and contradicts available evidence. Petitioner's amici also search vainly for something – even quasi-empirical – to support this claim, but they too come up empty-handed. See Br. of Amici Curiae Nat'l Ass'n of Subrogation Professionals, et al., in Support of Petitioner at 4-7 (U.S. May 25, 2012) (citing only an unsupported thought-experiment from fifteen years ago). To the extent this contention constitutes an important element in any analysis of the question presented (as petitioner and its amici clearly believes it should), this Court should wait for a case in which there is some record evidence on the issue. 10

⁹ Available at http://www.kff.org/insurance/ehbs-archives.cfm.

Petitioner's contention that "Third Circuit's ruling will introduce significant uncertainty – and significant new costs – into plan administration and litigation," Pet. 22, is equally unsupported by any record evidence. But even if true, this assertion could be (and has been) said about any case in which this Court has interpreted an ERISA provision in such a way as to expand a Plan's liability or limit its relief. See CIGNA, 131 S. Ct. at 1881 (expanding a Plan's liability); Glenn, 554 U.S. at 112 (expanding a Plan's liability); Knudson, 534 U.S. at 217 (limiting the availability of a Plan's relief); Varity, 516 U.S. at 489 (expanding a Plan's liability). And, this Court has repeatedly held, if a party is unhappy with the limitations or conditions imposed by (Continued on following page)

C. Requiring Courts to Apply Equitable Principles to Reimbursement Claims Would Not Create an Unworkable Mess.

Equally irrelevant and unsupported is petitioner's contention that the lower court's approach, which merely directs courts to apply principles of equity, would create an unwieldy, standard-less mess. See Pet. 20-24. As this Court has explained, the notion that forcing courts to sit in equity would engender confusion and force courts to undertake a "difficult[] ... task" are both "exaggerated" and, again, irrelevant. Knudson, 534 U.S. at 217. Although it is "easy to disparage the law-equity dichotomy as an ancient classification and an obsolete distinction," it is this "classification and distinction that has been specified by the statute." Id. (internal alterations and quotations omitted). When Congress passed Section 502(a)(3), it "felt comfortable referring to equitable relief . . . precisely because the basic contours of the term are well known." Id. Far from the "random" and "uncertain" world petitioner envisions, Pet. 17, 22, courts fashioning equitable relief "rarely" will need do anything more than consult the standard equitable treatises, as the lower court did here. Knudson, 534 U.S. at 217.

statute, those concerns are properly directed to Congress, not this Court. Knudson, 534 U.S. at 217.

Petitioner's scare tactics are also belied by the fact that courts in almost every other setting in which equitable reimbursement claims are permitted have had no problem fashioning relief in individual cases according to principles of equity. See, e.g., Ark. Dep't of Health & Human Servs. v. Ahlborn, 547 U.S. 268 (2006) (Medicaid reimbursement); Florence Cnty. Sch. Dist. v. Carter, 510 U.S. 7, 16 (1993) (reimbursement under the Individuals with Disabilities Education Act); Bradley v. Sebelius, 621 F.3d 1330 (11th Cir. 2010) (reimbursement under Medicare Secondary Payer statute); Werner v. Latham, 752 A.2d 832, 835 (N.J. App. Div. 2000) (reimbursement for state-governed health insurer); Aetna Life & Cas. Co. v. Nelson, 492 N.E.2d 386, 390 (N.Y. 1986) (same); Flanigan v. Dep't of Labor and Inds., 869 P.2d 14, 17 (1994) (reimbursement under worker's compensation statute).

Most notably, the approach adopted by the lower court here was recently – and resoundingly – endorsed by this Court in Ahlborn, which involved Medicaid reimbursement. There, the state of Arkansas sought to automatically impose a lien on any tort settlement obtained by a Medicaid recipient "in an amount equal to Medicaid's costs." 547 U.S. at 272. Under this approach, "when that amount [of Medicaid's costs] exceeds the portion of the settlement that represents medical costs, satisfaction of the State's lien [would] require[] payment out of proceeds meant to compensate the recipient for damages distinct from medical

costs – like pain and suffering, lost wages, and loss of future earnings." *Id*.

This Court squarely rejected that approach, refusing to allow Arkansas to "lay claim to more than the portion of [a Medicaid recipient's] settlement that represents medical expenses." Id. at 280. In so ruling, the Court noted that "[a] rule of absolute priority" poses the very real risk of "preclud[ing] settlement in a large number of cases," and works dramatic inequities "to the recipient in others." Id. at 288. Thus, allowing an entity to "share in damages for which it has provided no compensation . . . would be absurd and fundamentally unjust." Id. at 288 n.19 (internal quotations omitted). Exactly so. The lower court's decision here reflects this understanding.

Petitioner's attack on the lower court's approach also falls flat in light of this Court's reiteration, just two years ago, that the equitable side of the bench follows "a tradition in which courts of equity have sought to relieve hardships which, from time to time, arise from a hard and fast adherence to more absolute legal rules." Holland v. Florida, 130 S.Ct. 2549, 2563 (2010) (internal quotations omitted). "The flexibility inherent in equitable procedure," the Court explained, "enables courts to meet new situations that demand equitable intervention, and to accord all the relief necessary to correct . . . particular injustices." Id. (internal quotations omitted); see also Lemon v. Kurtzman, 411 U.S. 192, 200 (1973) ("In shaping equitable decrees, the trial court is vested with

broad discretionary power. . . . equitable remedies are a special blend of what is necessary, what is fair, and what is workable"); Willard v. Tayloe, 75 U.S. 557, 567 (1869) ("It is the advantage of a court of equity . . . that it can modify the demands of parties according to justice"). Petitioner's position would disinter these principles in exchange for a categorical rule of law, and in so doing, would perform an end run around the precise limitations Congress specified when it passed Section 502(a)(3).

IV. THE PROCEDURAL POSTURE OF THIS CASE MAKES IT A POOR VEHICLE FOR REVIEW.

Even if there were a cert.-worthy split in the lower courts, the interlocutory posture of this case renders it a poor vehicle for review. In the decision below, the Third Circuit merely reversed the district court's decision granting summary judgment to petitioner on its equitable reimbursement claim. In so doing, the court of appeals specifically declined to decide "what would constitute appropriate equitable relief for [the Plan]" because "equity calls for full factual findings rather than our speculation." Pet. App. 17a. The lower court further instructed that, "[o]n remand, the District Court should engage in any additional fact-finding it finds necessary" to "exercise its discretion to fashion 'appropriate equitable relief."

Given that there has been no actual finding of what would constitute appropriate equitable relief in this case, review would be premature. See, e.g., Bd. of Locomotive Firemen & Enginemen v. Bangor & Aroostook R.R. Co., 389 U.S. 327, 328 (1967); Va. Military Inst. v. United States, 508 U.S. 946, 946 (1993) ("[The Court] generally await[s] final judgment in the lower courts before exercising [its] certiorari jurisdiction") (Scalia, J., respecting denial of petition for writ of certiorari). "[E]xcept in extraordinary cases, the writ is not issued until final decree." Hamilton-Brown Shoe Co. v. Wolf Bros. & Co., 240 U.S. 251, 258 (1916).

Here, the interlocutory posture leaves unsettled factual questions that directly bear on the underlying applicable rules that petitioner asks the Court to employ. As the Third Circuit explained, "[f]actors such as the distribution of the third-party recovery between McCutchen and his attorneys . . . , the nature of their agreement, the work performed, and the allocation of costs and risks between the parties to this suit" all may inform the District Court's "exercise of its discretion to fashion 'appropriate equitable relief." Pet. App. 17a. And it remains possible that proceedings on remand will obviate the need for any further appeal in this case. Under these circumstances, the Court's preference for review upon final judgment is consistent with the Court's broader obligation to avoid unnecessary adjudication. See, e.g., Ala. State Fed'n of Labor v. McAdory, 325 U.S. 450, 461 (1945) ("It has long been [the Court's] considered

practice not to decide abstract, hypothetical or contingent questions. . . . ") (citations omitted).

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

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REPLY BRIEF

No. 11-1285

Supreme Cent. U.S.

JUN - 8 2012

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IN THE

Supreme Court of the United States

U.S. AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN,

Petitioner,

v.

JAMES McCutchen and Rosen, Louik & Perry, P.C., Respondents.

> On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

REPLY BRIEF IN SUPPORT OF CERTIORARI

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JAMES MCCUTCHEN and ROSEN, LOUIK & PERRY, P.C., Respondents.

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REPLY BRIEF IN SUPPORT OF CERTIORARI

SUMMARY OF ARGUMENT

Respondents concede that the decision below created a "split" among the circuits, Opp. 23, on a statutory provision so critical to ERISA's overall scheme that this Court has granted certiorari time and again to interpret it. Having retreated that far, Respondents are left to argue merely for delay: They quibble with the depth of the split; they call for yet more percolation; they assert that the Third Circuit's rule will cause ERISA plans no harm; they claim this case is a poor vehicle. Each argument fails.

- 1. The Third Circuit acknowledged that its decision created a circuit split. Pet. App. 14a-15a. Respondents nonetheless gamely attempt to explain that away. They can minimize the split, however, only by mischaracterizing the cases involved. Respondents argue, for example, that two decisions addressed only "the predicate question that this Court resolved in Sereboff [v. Mid Atl. Med. Servs.. Inc., 547 U.S. 356 (2006)]." Opp. 12. That is flatly wrong. Both actually decided the question presented here. Respondents argue that two other decisions "focused on an entirely different set of issues." Opp. That too is incorrect; those decisions address exactly the question now presented. And Respondents suggest that CIGNA Corp. v. Amara, 131 S. Ct. 1866 (2011), somehow erases the circuit split, but CIGNA did not change the governing legal principles in the least. The split is real; Respondents cannot wave it away.
- 2. Respondents also argue that further percolation is needed. Wrong again. Half the circuits have weighed in. None shows any sign of reversing itself. And as Petitioner has explained, the Third Circuit's rule has the potential to quickly become the de facto national rule in light of ERISA's elastic forum-selection provision. Pet. 23. Respondents, tellingly, ignore this point altogether. This Court need not await further percolation when the incorrect decision below is primed to begin distorting ERISA litigation right away, nationwide.
- 3. On the merits, Respondents argue that a rule enforcing ERISA plans as written is one of law, not equity, in violation of Section 502(a)(3). That argument betrays a basic misunderstanding of the relief at issue here: an equitable lien by agreement, which

works to give effect to an agreement between parties. The approach of the majority of circuits—which hews to the terms of the plan—honors both that equitable remedy and the plain language of Section 502(a)(3).

4. Finally, Respondents argue that the decision below—which authorizes judges to slash plan reimbursements on little else than a whim—will not "increas[e] plan costs and premiums." Opp. 30-32. Common sense belies that assertion, as do the cases and commentaries cited in the petition (at 21-23), by amici, and below. This Court should grant the writ and reverse.

ARGUMENT

I. THE SPLIT IS WELL-ARTICULATED AND REVIEW IS APPROPRIATE NOW.

- 1. The decision below acknowledged that it was splitting the circuits. Pet. App. 14a-15a. Faced with that obstacle, Respondents concede that there is what they dub a "post-Sereboff split." Opp. 23. But Respondents contend that Petitioner—and thus the Third Circuit itself—"overstate[]" the split because the decisions arrayed on the other side are distinguishable. Opp. 12. Not so.
- a. Respondents maintain that two of the five cited decisions—Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot, & Wansbrough, 354 F.3d 348 (5th Cir. 2003), and Administrative Committee of Wal-Mart Stores, Inc. v. Varco, 338 F.3d 680 (7th Cir. 2003)—"solely addressed the predicate question that this Court resolved in Sereboff:

¹ See Brief for National Ass'n of Subrogation Profils, et al. as Amici Curise Supporting Petitioner 4-10 ("NASP Amici Br.").

whether a claim for reimbursement is 'equitable[.]' "Opp. 12.

That is untrue. The Fifth and Seventh Circuits began by addressing "the predicate question that this Court resolved in Sereboff." See Bombardier, 354 F.3d at 355-358; Varco, 338 F.3d at 686-688. But both courts went on to answer a second question: whether equitable defenses such as the "commonfund doctrine"2 can "defeat[] the terms of an ERISA plan" expressly requiring full reimbursement from participants. Varco, 338 F.3d at 689-692; Bombardier, 354 F.3d at 360-362. Both answered "no." Varco, 338 F.3d at 691; Bombardier, 354 F.3d at 362. Both held that "[e]nrichment is not 'unjust' where it is allowed by the express terms of the plan," id. at 692 (citation omitted)—the precise opposite of the holding below. Pet. App. 16a.

As the Third Circuit itself concluded below, these decisions cannot be reconciled. Pet. App. 14a-15a. That conclusion holds more weight than Respondents' self-serving efforts to deny a split.

b. Even if the Court were to look only at postSereboff cases, moreover, the post-Sereboff decisions
discussed in the petition—Zurich Am. Ins. Co. v.
O'Hara, 604 F.3d 1232 (11th Cir. 2010); Administrative Comm. of Wal-Mart Stores, Inc. v. Shank, 500
F.3d 834 (8th Cir. 2007); and Moore v. CapitalCare,
Inc., 461 F.3d 1 (D.C. Cir. 2006)—similarly are
arrayed against the decision below. As we explained
(Pet. 12-14), each involved ERISA plan language
requiring full reimbursement; each confronted the
argument that full reimbursement was not "appro-

² The common-fund doctrine is an "equitable" defense. Dennis v. Higgins, 498 U.S. 439, 441 (1991).

priate" under Section 502(a)(3) because equitable defenses applied; and each rejected that argument, concluding that the plan must be applied as written. Those holdings squarely conflict with the decision below—which is why the Third Circuit acknowledged at least Shank and O'Hara, and explicitly broke with them. Pet. App. 15a; see also Moore, 461 F.3d at 10 (rejecting the make whole defense where the ERISA plan unambiguously required full reimbursement). Even discounting the pre-Sereboff decisions, then, the split is 3-1—the lineup that inspired review in Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002). See Pet. 15.

Respondents, naturally, seek to distinguish all of these decisions, too. They argue, for example, that Shank and O'Hara "merely held that federal common law does not limit the measure of relief under a Section 502(a)(3) claim for equitable reimbursement," and did not address "whether the statute itself * * * requires a court to apply equitable limitations on a claim for reimbursement under Section 502(a)(3)." Opp. 16-17 & n.6. That again is untrue. Both courts faced the same statutory argument Respondents make here. See Shank, 500 F.3d at 837 ("The Shanks contend[] that full reimbursement to the Committee is not 'appropriate' under section 502(a)(3)"); O'Hara, 604 F.3d at 1236 ("O'Hara argues that enforcement of the reimbursement and subrogation provision is not 'appropriate'" under Section 502(a)(3)). And both courts rejected it. unconvinced that "full recovery according to the terms of the plan is not 'appropriate' relief within the meaning of ERISA." Shank, 500 F.3d at 837; O'Hara, 604 F.3d at 1238. That these courts used the term "federal common law" to describe the beneficiaries' equitable theories changes nothing. After all, the theories in question—primarily the "make whole" doctrine—are part of the federal common law, but they are also equitable. See Pet. App. 9a n.2. That is why Respondents eventually retreat, in a footnote, from their meritless contention that Shank and O'Hara considered only "federal common law" and not "the statute itself." Opp. 17 n.6.

2. Respondents next argue that this Court's decision in CIGNA extinguishes the circuit split because (they say) "the lower court is the only court of appeals to address CIGNA's impact on claims for equitable reimbursement under Section 502(a)(3)." Opp. 22. That argument wildly overstates the Third Circuit's reliance on CIGNA. The court below did not even discuss CIGNA until long after it had already held that equitable principles could be used to rewrite ERISA contractual language. See Pet. App. 11a (articulating holding); id. 15a (discussing CIGNA). And when the court did discuss CIGNA, it did so merely to underscore the conclusion it had already reached on Section 502(a)(3)'s text: that equity is "sometimes less deferential to absolute freedom of contract." Id. 16a. CIGNA did not change the court's analysis.

Nor is CIGNA some sea-change decision that renders the circuit split illusory. CIGNA did not purport to alter the legal principles governing Section 502(a)(3). Quite the contrary: CIGNA is grounded in the Court's previous 502(a)(3) cases—Mertens v. Hewitt Assocs., 508 U.S. 248 (1993), Knudson, and Sereboff. See 131 S. Ct. at 1878-79. And CIGNA reaffirmed that the relief available under Section 502(a)(3) is limited to "traditional equitable relief," id. at 1879—which, as discussed below, is limited in



equitable-lien-by-agreement cases to enforcement of the parties' intended agreement.

Respondents' argument that review should be denied so the Court can wait and see whether "all subsequent courts agree with the lower court's reading of CIGNA," Opp. 22, fares no better. After all, the Third Circuit understood CIGNA to mean that "contractual language was not as sacrosanct as it is normally considered to be when applying breach of contract principles at common law." Pet. App. 15a. But as Petitioner explained (Pet. 18-19), that is plainly wrong. CIGNA suggested only that a court could rewrite an ERISA plan "to prevent fraud." 131 S. Ct. at 1879 (emphasis added). This Court correctly went no further, for equity cannot change contractual terms "in the absence of fraud" or the like. Manufacturers' Fin. Co. v. McKey. 294 U.S. 442, 449 (1935); accord Restatement (Second) of Contracts § 153 (1979). The court below, in short, erred both in applying CIGNA outside the fraud context and in understanding CIGNA to mean that judges sitting in equity enjoyed broad power to alter contracts. Those errors cut in favor of certiorari, not against it. See S. Ct. R. 10(c).

Finally, while "wait-and-see" approaches may work in some circumstances, they manifestly do not in the context of Section 502(a) due to its broad venue provision. Pet. 23. Because ERISA plan beneficiaries may sue wherever a defendant "may be found," 29 U.S.C. § 1132(e)(2), the Third Circuit's rule threatens to become the de facto rule nationwide, with no more "percolation" at all. Respondents offer no response—none—to this.

II. THE THIRD CIRCUIT WAS WRONG ON THE MERITS.

1. Respondents spend nearly half of their bulky opposition arguing the merits of the Third Circuit's decision. Their approach is understandable, given how little Respondents can muster against certiorari, but their merits arguments are just as wanting.

Respondents argue that the Third Circuit's holding is correct because the contrary approach embraced by five circuits—enforcing ERISA reimbursement provisions as written—"reads the words 'appropriate equitable relief' right out of the statute" and converts Section 502(a)(3) into "a legal remedy." Opp. 23. Respondents misunderstand both Section 502(a)(3) and the relief at issue in reimbursement cases.³

Section 502(a)(3) authorizes "appropriate equitable relief to enforce * * * * the terms of the plan." 29 U.S.C. § 1132(a)(3) (emphasis added). The "terms of the plan," therefore, are what is to be "enforce[d]," and the statute requires courts to ask whether there is an appropriate equitable remedy available to "enforce" them. Id. This Court has made that quite clear: Section 502(a)(3) "does not, after all, authorize 'appropriate equitable relief at large, but only 'appropriate equitable relief for the purpose of * * *

³ Respondents also point to Arkansas Department of Health & Human Services v. Ahlborn, 547 U.S. 268 (2006), contending that that decision categorically disapproves of provisions calling for full reimbursement. Opp. 34-35. Ahlborn involved the Medicaid statute, which expressly limits reimbursement rights "to payment for medical care from any third party." Id. at 280 (citation omitted). It is hardly surprising that the Court rejected a state's attempt to claim an award compensating a beneficiary for costs other than medical care. See id.

'enforc[ing] any provisions of ERISA or an ERISA plan.'" Mertens, 508 U.S. at 253.

That basic principle is crucial. It hews closely to the remedy—equitable lien by agreement—this Court approved in Sereboff. Equitable liens by agreement are grounded in the maxim that "equity will regard that as done which was agreed to be done," Runstetler v. Atkinson, 11 D.C. 382, 384 (1883) (emphasis added); accord 51 Am. Jur. 2d Liens § 40. The remedy thus enforces an actual agreement between parties; it "cannot be invoked to create a right contrary to the agreement of the parties." Good v. Jarrard, 93 S.C. 229, 239 (1912). And what was "agreed to be done," Runstetler, 11 D.C. at 384, is just that; it is not what a laterarriving judge sitting in equity thinks ought be done.

In light of these principles, it makes sense that a court applying Section 502(a)(3) would enforce a reimbursement provision as agreed upon, not as modified by some extrinsic notion of fairness. That does not transform the relief into a "legal remedy." Opp 23. Quite the contrary: The provision as agreed upon is the sine qua non of the equitable lien by agreement, and enforcement of the lien accordingly "enforce[s] * * * the terms of the plan." 29 U.S.C. § 1132(a)(3). A modified reimbursement amount would not enforce the terms of the plan, and could not be considered "appropriate equitable relief" under Section 502(a)(3).4

The Third Circuit strayed by confusing the equitable lien by agreement with its more nebulous cousin, the equitable lien to prevent unjust enrichment. See Pet. App. 11a-12a. The treatises and cases explicitly distinguish the two. See 1 D.B. Dobbs, Law of Remedies § 4.3(3), at 601-602 (2d ed. 1993); Sereboff, 547 U.S. at 364-365.

2. Respondents next argue that the Third Circuit's rule is faithful to ERISA, and that the majority rule is not, because "the primary purpose of ERISA is to protect people participants and beneficiaries not plans." Opp. 28. Quite so. ERISA is not drawn up to protect one particular participant or beneficiary; it protects all. Which is why the principle Respondents embrace cuts against the Third Circuit's rule. ERISA "recognizes the need to preserve assets to satisfy future, as well as present, claims and requires a trustee to take impartial account of the interests of all beneficiaries." Varity Corp. v. Howe, 516 U.S. 489, 514 (1996). And as courts have recognized. "[r]eimbursement inures to the benefit of all participants and beneficiaries by reducing the total cost of the Plan." O'Hara, 604 F.3d at 1238. The solution that best protects all beneficiaries is to enforce the plan's terms as written. Id. at 1237-38; Shank, 500 F.3d at 838; NASP Amici Br. 12-13.

III. THE DECISION BELOW WILL SEVERELY HARM ERISA PLANS.

1. Respondents argue that the rule adopted below "would not * * * increas[e] plan costs and premiums." Opp. 30. That is incorrect. Courts and commentators have long recognized that when plans cannot recover reimbursement, their increased costs are "defrayed by other plan members" via "higher premium payments." O'Hara, 604 F.3d at 1238; accord Shank, 500 F.3d at 838; see also, e.g., M.C. Campbell, Non-Consensual Suretyship, 45 Yale L.J. 69, 100 (1935); NASP Amici Br. 7-10. And if such a plan does not increase premiums, the plan must absorb the additional costs itself—an outcome that undis-

- putedly will threaten some plans' solvency. Pet. 21-22. Respondents' assertion to the contrary is absurd.
- 2. Respondents likewise contest Petitioner's observation that the lower court's approach—prizing individualized approaches to "equity" over plain plan language-"would create an unwieldy, standard-less mess." Opp. 33. Never fear, Respondents say; "courts fashioning equitable relief 'rarely' will need do anything more than consult the standard equitable treatises, as the lower court did here." Id. (citation omitted). But the Third Circuit certainly did not "fashion[] equitable relief" by merely consulting a treatise. It did not fashion equitable relief at all. Instead, it announced a legal rule, then remanded the case with instructions for the District Court to "engage in any additional fact-finding it finds necessary" and consider, among other things, "the work performed," and "the allocation of costs and risks between the parties." Pet. App. 17a. It is that process, repeated ad infinitum in many courts, that "will introduce significant uncertainty-and significant new costs-into plan administration and litigation." Pet. 22. Respondents' argument again proves Petitioner's point.
- 3. Respondents also argue that courts in other equitable reimbursement settings "have had no problem fashioning relief in individual cases." Opp. 34. But the issue is not whether courts would have trouble fashioning relief in those "individual cases"; it is whether that case-by-case determination would reduce employers' incentive "to offer benefits by assuring a predictable set of liabilities," as ERISA is supposed to do. Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 379 (2002). Where the "predictable set of liabilities" is left largely to chance and

circumstance, the answer, obviously, is yes. See NASP Amici Br. 8-10.

IV. THIS CASE PROVIDES AN IDEAL VEHICLE.

Finally, Respondents attack this case's suitability as a vehicle. But the question presented—as framed by both parties—is a purely legal one. No action the District Court could take would have any bearing on the Third Circuit's holding regarding Section 502(a)(3). Either a court can rewrite ERISA plans as part of "appropriate equitable relief" (as the Third Circuit held) or it cannot (as the Fifth, Seventh, Eighth, Eleventh, and D.C. Circuits held). And Petitioner's injury cannot be mooted on remand because the Third Circuit has already determined that "the judgment requiring McCutchen to provide full reimbursement to US Airways constitutes inappropriate and inequitable relief." Pet. App. 16a.

This Court regularly grants review in cases, like this one, where the court of appeals has announced a legal rule worthy of review and remanded for further proceedings. See, e.g., Filarsky v. Delia, 132 S. Ct. 1657 (2012); FAA v. Cooper, 132 S. Ct. 1331 (2012); Arizona Free Enterprise Club's Freedom Club PAC v. Bennett, 131 S. Ct. 2806 (2011). This Court should do the same here and resolve the split.

CONCLUSION

Respondents' own Question Presented asks whether ERISA beneficiaries must fully reimburse their ERISA plans "simply because the plan language so provides." Opp. i. This Court's decisions, and the great weight of the circuits, supply the answer: Yes.

For the foregoing reasons, and those in the petition, the petition should be granted.

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June 2012

AMICUS CURIAE BRIEF

No. 11-1285

MAY 2 5 2012 OFFICE OF THE CLERK

In the Supreme Court of the United States

U.S. AIRWAYS, INC., in its capacity as
Fiduciary and Plan Administrator of the
U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN,
Petitioner,

v.

James McCutchen and Rosen, Louik & Perry, P.C., Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF AMICI CURIAE FOR NATIONAL ASSOCIATION
OF SUBROGATION PROFESSIONALS, THE SELF
INSURANCE INSTITUTE OF AMERICA, INC., AND
THE WESTERN PENNSYLVANIA TEAMSTERS
AND EMPLOYERS WELFARE FUND
IN SUPPORT OF PETITIONER

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The National Association of Subrogation Professionals ("NASP"), Self-Insurance Institute of America, Inc. ("SIIA"), and the Western Pennsylvania Teamsters and Employers Welfare Fund ("WPTEWF") respectfully submit this brief supporting the Petitioner as amicus curiae.¹

STATEMENT OF INTEREST

NASP. NASP is a non-profit trade association of insurance companies, third party administrators, subrogation specialists, and attorneys practicing in the field of subrogation and recovery. NASP has approximately 2,000 members, representing more than 150 insurance companies and self-funded entities. The purpose of NASP is to "create a national forum for the education, training, networking and sharing of information and, ultimately, the most effective pursuit of subrogation on an industry-wide basis."

Through NASP, members are able to retrieve, organize, exchange information, and expand the use of technology to promote subrogation efforts on a cost effective basis. The members of NASP recover hundreds of millions of dollars in health care expenditures every year for insured and self-funded employee benefit plans through subrogation and recovery practices.

¹ Notice was provided to all counsel on November 16, 2012 and all parties have consented. No counsel for a party authored this brief in whole or in part. No party, or counsel for a party, made a monetary contribution intended to fund the preparation or submission of the brief. No one other than the *amici*, their members, and their counsel made such a contribution.

NASP has an interest in the issue presented in this case — whether ERISA allows courts to use equitable principles to re-write plan terms requiring reimbursement. The Court's decision will have a profound impact on employee benefit plans' financial stability, which in turn will have far reaching implications for the nation's health care system.

SIAA. SIAA is a non-profit organization with nearly 1,000 members, serving tens of millions of health plan beneficiaries, dedicated to the advancement and protection of the self-insurance industry. SIIA's membership includes self-insured entities such as employer plan sponsors, as well as service providers such as third party administrators, reinsurance companies, and other entities that support the self-insurance business. SIIA is the only organization in the United States that exclusively represents firms, professionals, and organizations that participate in the broad spectrum of self-insurance, including self-insured group health plans.

Through SIIA, its members coordinate their views and provide practical information and recommendations to government and the public at large on a range of subjects relevant to the effective functioning of the self-insurance system, including the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, et seq., that concern self-insured health plans and plan participants. SIIA's mission includes rendering assistance to courts in their deliberations on significant self-insured health plan issues of broad concern to its members.

WPTEWF. The Western Pennsylvania Teamsters and Employers Welfare Fund is a self-insured multiemployer welfare fund administered Pittsburgh, PA which provides medical and ancillary benefits to approximately 5,000 participants and beneficiaries. Its fiduciaries have a duty under ERISA to pursue subrogation under the written terms of a plan document which provides for broad subrogation of all rights when some other party may have liability for an occurrence which has caused the need for benefits. The WPTEWF joins this amicus brief in support of the petition in order to alert the Court to the serious disruptive impact of the Third Circuit's decision on itself and other self-insured plans throughout the country. As is typical with larger and even medium sized ERISA plans, the Welfare Fund has had participants with claim/subrogation matters situated throughout the United States. A conflict of authority between the Courts of Appeals raises the possibility that the Welfare Fund will be unable to uniformly administer its subrogation provisions because, depending on which federal circuit jurisdiction may be involved, courts may feel compelled to adjudicate equitable principles, rather than review the fiduciary's administration of plan provisions as written.

SIAA, NASP and WPTEWF have a strong interest in preserving their members' ability to recover plan funds from participants that accept medical benefits but then refuse to honor the reimbursement terms of their agreements after obtaining compensation from third parties through legal action or settlement. Amici's members depend on reimbursement to ensure solvency of their plans and to provide benefits to all participants at lower costs. To the extent that Amici's members are barred from seeking reimbursement

according to the terms of the plan, they might be forced to take dramatic action, such as increasing contributions, reducing benefits, or otherwise amending plan terms to protect against the growing and unnecessary risk. Each of these scenarios would result in a reduction in health care insurance for the nation's workforce.

ARGUMENT

The decision below is a danger to employer-sponsored health plans. The principle endorsed in *McCutchen* will make it more difficult and expensive for employers to sponsor benefit plans. It will increase ERISA administrative costs and litigation burdens. It will impose new burdens on *other* plan participants. And by splitting the circuits, it destroys the legal uniformity ERISA was designed to foster. The petition for certiorari should be granted, and the Third Circuit's decision reversed.

- I. THE DECISION BELOW WILL MAKE IT MORE DIFFICULT AND EXPENSIVE TO SPONSOR AND MAINTAIN AFFORD-ABLE EMPLOYEE BENEFIT PLANS.
 - A. Subrogation and Reimbursement Provisions Help Keep Health Care Coverage Affordable.

The healthcare industry is one of the largest and most expensive industries in the United States. Evidence of an impending health care cost crisis is clear. According to an annual survey by the Kaiser Family Foundation and Health Research and Educational Trust, annual healthcare spending in the

United States reached \$22 trillion in 2007, which is 16.2% of the Gross Domestic Product. See Health Care Costs, A Primer (March 2009). The average cost of health care amounts to approximately \$7,421 per person annually. Id. at 2. Since 1999, premiums have significantly outpaced both inflation and wage increases. Id. at 10.

The importance of subrogation and reimbursement as a mechanism to preserve plan assets can hardly be disputed. In an era of rising health care expenses, cost containment measures such as subrogation and reimbursement are critical to the ability to keep benefits affordable. The elimination or reduction of these recoveries would make health coverage, which is already difficult for many Americans to afford, even more expensive. The Maryland General Assembly, for example, has estimated that health insurance premiums for state workers would rise between 1% and 2% if insurers' ability to enforce subrogation and reimbursement provisions were eliminated.3 And those sorts of premium increases in turn restrict individuals' access to coverage. For every 1% increase in premiums, approximately 300,000 Americans are unable to afford health coverage and employees experience a \$12.3 billion wage loss.

Subrogation and reimbursement provisions are particularly important in allowing employers and unions to sponsor and maintain self-funded employee

² http://www.kff.org/insurance/upload/7670_02.pdf (accessed on 5/17/12).

³ mlis.state.md.us/2000rs/fnotes/bil_0003/sb0903.rtf

welfare plans. For self-funded plans, subrogation and reimbursement recoveries "inure[] to the benefit of all participants and beneficiaries by reducing the total cost of the plan." Zurich Am. Ins. Co. v. O'Hara, 604 F.3d 1232, 1237 (11th Cir. 2010). That is important because access to affordable coverage becomes even more difficult when employers are no longer able to offer welfare plans that subsidize the cost of the benefits. A survey by the United States Census Bureau, as reported in the New York Times, showed that after four years of rising health care costs, the percentage of people receiving health benefits from their employer dropped from 63.6% in 2000 to 59.8% in 2004.

The cost savings generated by subrogation and reimbursement, in short, are passed on to employers and employees in the form of lower premiums for insured plans, or contributions for self-funded plans. One legal scholar at the University of Chicago explained how subrogation impacts the insurance premium calculation:

An insurance company sets its rates based on historical net costs. Thus, if the insurer had one hundred policy holders in the experience period, and experienced a total of \$20,000 in claim costs, it will set its actuarial premiums at \$200 per policy holder. If, on the other hand, the insurance company experienced \$20,000 in claim costs and received \$5,000 in subrogation

⁴ See David Leonhardt, Poverty in U.S. Grew in 2004, While Income Failed to Rise for 5th Straight Year, N.Y. Times, August 31, 2005 at A9.

[or over payment reimbursement], it will set its actuarial premiums at \$150 per policy holder.⁵

As Judge Posner opined in Cutting v. Jerome Foods, Inc., 993 F.2d 1293, 1297 (7th Cir. 1993): "Without subrogation, a part of the risk is shifted back to the insured. He pays more for the insurance because he retains . . . a right to obtain through litigation a recovery that may actually exceed the actual loss that (after receiving insurance proceeds) he suffered."

B. The Decision Below Will Increase The Cost of Pursuing Subrogation And Reimbursement, Hindering Plan Fiduciaries' Ability to Protect Plan Assets.

This Court has held that plan asset protection is a critical policy goal underlying ERISA. Specifically, this Court has stated:

A fair contextual reading of the statute makes it abundantly clear that its draftsmen were primarily concerned with the possible misuse of plan assets and with remedies that would protect the entire plan, rather than the rights of an individual beneficiary.

Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 142 (1985) (emphasis added). In fact, ERISA specifically requires that a plan fiduciary act solely in the interest

⁵ See Jeffrey A. Freenblatt, Insurance and Subrogation: Where the Pie Isn't Big Enough, Who Eats Last? 64 U. Chi. L. Rev. 1337, 1355 (1997).

of all plan participants and beneficiaries for the exclusive purpose of: (1) providing benefits to participants and beneficiaries; and (2) defraying the reasonable expenses of administering the plan. 29 U.S.C. § 1104(a)(1)(A).

The McCutchen decision completely disregards this when interpreting the scope of "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3). U.S. Airways, Inc. v. McCutchen, 663 F.3d 671, 679 (3d Cir. 2011) ("Finally, U.S. Airways raises a practical concern that the application of equitable principles will increase plan costs and premiums. This concern does not address the statutory language[.]"). Instead, McCutchen crafts a mechanism for plan participants and beneficiaries to avoid unambiguous terms of an ERISA plan. It encourages participants and beneficiaries to accept benefits under the plan's terms, but then to refuse to honor those terms at the expense of all other participants and beneficiaries.

That approach will be harmful for plans both because it reduces their subrogation recoveries and because it dramatically increases their administrative and litigation burdens. First, in order to meet ERISA's mandate that fiduciaries administer the plan "in accordance with the documents and instruments governing the plan," plan fiduciaries will be forced to litigate subrogation and reimbursement claims in federal district court. Thus, the McCutchen decision will generate more ERISA litigation.

Second, each personal injury case is different and the use of "equitable remedies" (such as unjust enrichment or the make-whole or common fund doctrines) to subvert plain plan language unnecessarily increases the administrative burdens on plans. Instead of relying on the predictability offered by the plan's terms, plans will be required to thoroughly investigate and verify each element of the damages claim in order to determine, for example, if the injured plan participant is being fully compensated for medical expenses. This activity will needlessly increase the cost of operating a plan while at the same time reducing plan recoveries.

Third, the McCutchen approach will cause ERISA litigation to take more of the court's time and increase litigation costs for the parties. No longer will ERISA litigation be a matter of determining whether the plan administrator is acting according to plan terms. Instead, each case will require a factual hearing in which the outcome depends solely upon an individual judge's notion of fairness.

The increased cost of litigating an ERISA subrogation or reimbursement claim will lead to: (1) higher administrative costs of sponsoring and maintaining an employee welfare plan; and/or (2) the loss of subrogation and reimbursement recoveries as enforcement of the claims becomes economically unfeasible. Either outcome will result in increased

⁶ See Cutting, 993 F.2d at 1298 (" "It can also be argued against the make-whole rule that it is administratively more complex, requiring the medical insurer to calculate the insured's total medical and nonmedical loss, and therefore that it makes insurance (or its equivalent in this case) more expensive to the insured – and makes it more expensive to him for the additional reason that he will have to pay for the additional coverage that the rule in effect provides.")

premium or contributions for all participants and beneficiaries.

That is not how ERISA is supposed to work, either under the statute or this Court's case law. The fact of the matter is, someone must pay the cost of benefits provided under self-funded ERISA plans. If the plan's right to full reimbursement is denied, the cost of paying for the underlying benefits falls to the plan's sponsor and to others who make the contributions that support plan benefits. Plan reimbursement and subrogation provisions help to preserve the assets of self-funded plans, so that those assets remain available to pay present and future claims for all participants. See Admin. Comm. of the Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan v. Shank, 500 F.3d 834, 838 (8th Cir. 2007), cert. denied, 128 S.Ct. 1651 (2008) ("Shank would benefit if we denied the committee its right to full reimbursement, but all other Plan members would bear the costs in the form of higher premiums"). The decision below should be reversed so that those reimbursement and subrogation provisions can continue to function as they were intended.

II. THE DECISION BELOW VIOLATES FOUNDATIONAL PRINCIPLES OF ERISA.

A. The Third Circuit's Decision Creates Uncertainty And Burdens That ERISA Was Designed To Avoid.

ERISA contains certain foundational principles necessary for plans to function as Congress intended. Among those principles: The plan administrator has the right to design its plan without courts dictating the

terms and conditions. The administrator has the right to have the plan's terms enforced as written. And plan administrators and participants have the right to rely on the written plan document, the uniform application of the law, freedom from undue administrative costs and burdens, and freedom from excessive litigation. The decision below frustrates each and every one of these foundational principles and, if it is not overturned, will make consistent administration of ERISA plans unnecessarily difficult.

ERISA "does not regulate the substant. re content of welfare-benefit plans." Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 732 (1985). Federal courts are likewise loath to "dictate the content of a welfare benefit plan." Hickey v. A.E. Staley Mfg., 995 F.2d 1385, 1392 (7th Cir. 1993). Under ERISA "employers have large leeway to design disability and other welfare plans as they see fit." Harris v. Harvard Pilgrim Health Care, Inc., 208 F.3d 274, 277 (1st Cir. 2000). "A subrogation provision affects the level of benefits conferred by the plan, and ERISA leaves that issue to the private parties creating the plan." Waller v. Hormel Foods Corp., 120 F.3d 138, 140 (8th Cir. 1997). All of these principles flow from a fundamental fact about the statute: "ERISA's statutory scheme is built around reliance on the face of written plan documents." Kennedy v. Plan Adm'r for DuPont Sav' & Inv., 555 U.S. 285, 301 (2009).

The decision in *McCutchen* departs from these principles and superimposes "equitable doctrines" on plans under the guise that the "other appropriate equitable relief" provision of ERISA requires such a result. If *McCutchen* is not reversed, the right of plan administrators and plan participants to rely on their

written plan documents would be nullified. Courts would be free to modify plan provisions even when the modification is against the express terms of the plan, as is the case in *McCutchen*. Federal common law would be allowed to trump clear plan language – an abrogation of established ERISA law. Such modifications unnecessarily frustrate the specific requirement of ERISA that every employee benefit plan be established and maintained pursuant to a written instrument that specifies the basis on which payments are made to and from the plan.

- 2. Indeed, ERISA specifically identifies a key feature of plan documents: They "specif[y] the basis on which payments are made to . . . the plan." 29 U.S.C. § 1102(b)(4). A subrogation or reimbursement recovery is a payment "to" a plan. It is therefore the specific purview of the plan documents to define the basis upon which a plan receives subrogation or reimbursement payments. The decision below ignores that statutory directive. As this Court pointed out in Kennedy, there is "wisdom" in protecting the "plan documents rule"—i.e., the fundamental ERISA principle that the plan's terms should govern. 555 U.S. 285, 303. McCutchen flies in the face of that wisdom by eliminating, or at least altering, the written requirement obligating payment to the plan.
- 3. The decision below also causes inequity for all the other members of a plan. Courts have consistently acted to protect contractually defined benefits in an ERISA plan, see Duggan v. Hobbs, 99 F.3d 307, 309-10 (9th Cir. 1996), and are loath to apply common-law principles to override unambiguous plan provisions based on perceived exigencies. Davidian v. S. Calif. Meat Cutters Union & Food Emps. Benefit Fund, 859

F.2d 134, 136 (9th Cir. 1988); Ryan v. Fed. Express Corp., 78 F.3d 123, 127-28 (3d Cir. 1996) ("[I]t would be inequitable to allow a plan participant to partake of the benefits of the Plan and then, after they had received a substantial settlement, invoke common law principles to establish a legal justification for their refusal to satisfy their end of the bargain."). Allowing plan participants to escape their obligations to reimburse plans from third party settlements harms other plan members by reducing the amounts available to pay other claims. That approach undermines a basic purpose of ERISA: to protect all beneficiaries of a Plan. See Mass. Mut. Life, 473 U.S. at 142.

B. The Decision Below Splits The Circuits And Creates The Risk Of Non-Uniform Outcomes.

Finally, the decision below undermines ERISA uniformity – and splits the circuits in the process.

1. The express intent of ERISA is to ensure that plans and plan sponsors "would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. Otherwise the inefficiencies created could work to the detriment of plan beneficiaries." Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990). As the Court in Ingersoll-Rand observed: "It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds

with the goal of uniformity that Congress sought to implement." Id. at 142.

2. That is precisely the problem plans face in light of the decision below. In *McCutchen*, the Third Circuit imposed the common fund and make-whole doctrines under the rubric of "unjust enrichment," even though the plan specifically provided for a right of full recovery. That destroyed a lower-court consensus: Application of those doctrines to properly drafted plans has been soundly rejected in over one hundred federal court decisions, including several in the Third Circuit itself. Those decisions enforced clear language requiring reimbursement, whether by relying on specific language disclaiming the applicability of equitable doctrines, or by relying upon clearly defined rights of full recovery.

In Bill Gray Enterprises, Inc. Employee Health & Welfare Plan v. Gourley, 248 F.3d 206 (3d Cir. 2001), for example, the court noted that "courts have held that importing federal common law doctrines to ERISA plan interpretation is generally inappropriate, particularly when the terms of an ERISA plan are clear and unambiguous." Id. at 220 n.13. Accord Bollman Hat Co. v. Root, 112 F.3d 113, 117 (3d Cir.), cert. denied, 522 U.S. 952 (1997); Ryan, 78 F.3d at 126; Cagle v. Bruner, 112 F.3d 1510 (11th Cir. 1997), reh'g denied, 124 F.3d 223 (1997) ("Because the make whole doctrine is a default rule, the parties can contract out of the doctrine."); Cutting, 993 F.2d at 1297 ("Because make whole rule is just a principle of interpretation it can be overridden by clear language in the plan"). Likewise, in Harris, the First Circuit wrote: "Where an ERISA plan requires without qualification that plan participants reimburse the plan

for benefits paid, the plan should not be construed to depend upon an implied contingency such as the 'make whole' doctrine particularly since ERISA specifically plans be envisions that covered written straightforward language comprehensible by the average plan participant." 208 F.3d at 279. Those decision are straightforward applications of a basic ERISA principle: "The authority of the courts to develop a 'federal common law' under ERISA is not the authority to revise the text of the statute." Mertens v. Hewitt Assocs., 508 U.S. 248, 260 (1993); accord Ryan, 78 F.3d at 126 ("straight forward language . . . [in an ERISA plan documentl should be given its natural meaning"). Applying that principle, federal courts long have rejected attempts to apply doctrines arising out of the theory of unjust enrichment—such as both the make-whole and the common fund doctrines-to ERISA plans in the manner envisioned by McCutchen.

Indeed, the court below acknowledged that its opinion is at odds with the Fifth, Seventh, Eighth and Eleventh Circuits. In those latter cases, plan members posited the same theory as McCutchen—that "equitable relief" must be judged "appropriate" versus "inappropriate" by examining whether requiring the individual to reimburse the plan is "equitable" or "inequitable." And in all of those cases, the courts rejected the argument. They determined that the plans' actions to enforce the reimbursement provisions

⁷McCutchen, 663 F.3d at 678, referencing the decisions of Zurich, 604 F.3d 1232 (11th Cir.); Shank, 500 F.3d at 838 (8th Cir.); Bombardier Aerospace Emp. Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough, 354 F.3d 348 (5th Cir. 2003); Admin. Comm. of the Wal-Mart Stores, Inc. Assoc. Health & Welfare Plan v. Varco, 338 F.3d 680 (7th Cir. 2003).

constituted "appropriate" equitable relief despite the fact that the participants had not been made whole by their tort settlements.

3. Were McCutchen to stand, it would badly undermine the well-defined, uniform and easily administered law that has developed on this issue and put in its place an uncertain, non-uniform, costly regime that will benefit a relatively few individuals at the cost of all plan participants. But it also would allow for still more disunity to develop among the federal courts, because the courts would not just divide on whether to apply equitable remedies; they also likely would divide on how to apply them.

Equitable relief is, of course, a broad and malleable concept. It is foreseeable that different federal courts, exercising common law powers, will develop different versions of that relief, requiring plans to tailor their conduct to the peculiarities of the law of each jurisdiction. Indeed, the make-whole doctrine provides a good example, because the precise contours of the doctrine vary widely by jurisdiction. Some jurisdictions apply it in a strict fashion, holding that if an injured individual's damages exceed his or her recovery, there is no entitlement to subrogation. Other jurisdictions apply the doctrine using a sliding-scale approach. Still others prohibit subrogation or reimbursement in the case of automobile accidents but not medical malpractice.

The point is simple: If *McCutchen* were the law, it would not impose some uniform equitable principle on plans. Instead, the version of equity to which a plan was subject would vary depending on the jurisdiction where a case is brought and the sources a court

references to determine how "equity" applies. This Court has held, in *Ingersoll* and elsewhere, that that type of outcome is unacceptable and fundamentally at odds with the goals of Congress. It should grant review here and reaffirm the fundamental principle designed to ward off just such disunity: ERISA requires reliance on the face of the written plan document.

The intent of ERISA is to create a uniform system for the administration of claims. ERISA was specifically enacted so that plan administrators could avoid having to master the laws of multiple jurisdictions and contend with large amounts of litigation. The goal of Congress was to minimize the administrative and financial burdens of operating a plan enforcing them as written. Egelhoff v. Egelhoff, 532 U.S. 141, 121 S.Ct. 1322, 149 (2001). The decision below is in direct opposition to the specific reasons that ERISA was enacted.

III. The Decision Below Is Based on A Fundamentally Flawed Interpretation of 29 U.S.C. 1132(a)(3).

For all of the above reasons, McCutchen endangers employer-sponsored benefit plans and undercuts legal uniformity. But it is also incorrect. Its requirement that "equitable relief" is subject to the further test of whether it is "appropriate" for a specific individual contradicts well-established ERISA law and policy.

1. Contrary to the reasoning in the McCutchen decision, "appropriate" merely modifies "equitable

relief" in the context of the entire provision. As this Court explained, "appropriate" as used under 29 U.S.C. 1132(a)(3) describes whether a particular remedy is available. Varity Corp. v. Howe, 516 U.S. 489, 515 (1996) ("[W]here Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be 'appropriate.'")

This Court has placed a high value on the appropriateness of "protect[ing] contractually defined benefits." Russell, 473 U.S. at 148. While individual plan participants' positions are centered on their personal concerns, the courts reflect broader considerations. The "appropriateness" of the relief must not be measured based on one individual but on the entire plan. Further, courts are instructed to enforce the plain language of an ERISA plan "in accordance with its literal and natural meaning" and to refrain from applying common law theories to "alter the express terms of an ERISA plan." Shank, 500 F.3d at 838 (internal citations omitted).

2. McCutchen's interpretation of "appropriate" is also inconsistent with the holding in Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356 (2006). In an action also arising under 29 U.S.C. § 1132(a)(3), the Sereboff Court held that by seeking an equitable lien, the ERISA plan could "rely upon a familiar rule of equity to collect for the medical bills it paid on the Sereboff's behalf." Id. at 363-64. Not only did the Court hold that imposition of a constructive trust or equitable lien constituted "appropriate equitable relief," but it held that the "parcel of equitable defenses the Sereboff's claim accompany any such action are beside the point." Id. at 368. The equitable

defenses did not matter because the plan's enforcement of its equitable lien by agreement was in and of itself appropriate equitable relief.

After Sereboff was decided, plan administrators throughout the country came to rely on the holding that it is "appropriate equitable relief" for a plan to seek to enforce a constructive trust and equitable lien. McCutchen now prevents reliance upon the approved remedy of seeking to enforce a constructive trust and equitable lien.

If the McCutchen interpretation were upheld, it would mean plan reimbursement provisions must be adjudicated on a case-by-case basis so the injured party can have a determination on whether he or she was made whole by a third party settlement. McCutchen theorizes that reimbursement is only acceptable if the plan participant has been made whole from the settlement and still has funds left over to reimburse the ERISA plan. Under this theory, a court must become involved any time a plan participant refuses to repay an ERISA Plan with a reimbursement That approach would frustrate one of provision. Congress' primary goals in enacting ERISA: to promote a uniform enforcement of employment benefit plans. See Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9 (1987).

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

John D. Kolb

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JOINT APPENDIX

No. 11-1285

Supreme Court, U.S. FILED

AUG 2 9 2012

OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

U.S. AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN,

Petitioner,

v.

JAMES MCCUTCHEN AND ROSEN, LOUIK & PERRY, P.C.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED APRIL 25, 2012 CERTIORARI GRANTED JUNE 25, 2012

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IN THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 10-3836

US AIRWAYS, INC.,

Plaintiff-Appellee,

V.

JAMES E. McCUTCHEN, and ROSEN LOUIK & PERRY, P.C.,

Defendants-Appellants.

DOCKET ENTRIES

DATE	PROCEEDINGS
09/24/2010	CIVIL CASE DOCKETED. Notice
	filed by Appellants James E.
	McCutchen and Rosen Louik &
	Perry in District Court No. 2-08-cv-
	01593. (TMM)
01/07/2011	BRIEFING NOTICE ISSUED. Brief
	on behalf of Appellant James E.
	McCutchen and Appellant Rosen
	Louik & Perry due on or before
	02/16/2011. Appendix due on or
	before 02/16/2011. (TMM)

DATE	PROCEEDINGS
02/16/2011	ECF FILER: ELECTRONIC BRIEF on behalf of Appellants James E. McCutchen and Rosen Louik & Perry, filed. Certificate of Service dated 02/16/2011 by ECF, US mail. (PH)
02/16/2011	ECF FILER: ELECTRONIC APPENDIX on behalf of Appellants James E. McCutchen and Rosen Louik &Perry, filed. Certificate of Service dated 02/16/2011 by ECF, US mail. (PH)
02/17/2011	HARD COPY RECEIVED from Appellants James E. McCutchen and Rosen Louik & Perry – Brief with Volume I of Appendix attached. (KEL)
02/17/2011	HARD COPY RECEIVED from Appellants James E. McCutchen and Rosen Louik & Perry – Appendix. Copies: 4. (Volume I attached to Brief). (LAL)
03/18/2011	ECF FILER: ELECTRONIC BRIEF on behalf of Appellee US Airways Inc, filed. Certificate of Service dated 03/18/2011 by ECF, US mail. (SHP)
03/21/2011	HARD COPY RECEIVED from Appellee US Airways Inc – Brief. (KEL)

DATE	PROCEEDINGS
04/01/2011	ECF FILER: ELECTRONIC REPLY BRIEF on behalf of Appellants James E. McCutchen and Rosen Louik & Perry, filed. Certificate of Service dated 04/01/2011 by ECF, US mail. (PH).
04/04/2011	HARD COPY RECEIVED from Appellants James E. McCutchen and Rosen Louik & Perry – Reply Brief. (SJB)
04/13/2011	Calendared for Monday, 07/11/2011. (TLW)
06/06/2011	ECF FILER: Letter dated 06/06/2011, filed pursuant to Rule 28(j) from counsel for Appellants James E. McCutchen and Rosen Louik & Perry. This document will be SENT TO THE MERITS PANEL, if/when applicable. (PH)
06/29/2011	Oral Argument Notification for Monday, 07/11/2011. (TLW)
07/11/2011	Argued on Monday, July 11, 2011 before SLOVITER, FUENTES and VANASKIE, Circuit Judges. Noah G. Lipschultz arguing for Appellee US Airways Inc; Matthew W.H. Wessler arguing for Appellants James E. McCutchen and Rosen Louik & Perry. (TLW).

DATE	PROCEEDINGS
08/08/2011	ECF FILER: Letter dated 08/08/2011, filed pursuant to Rule 28(j) from counsel for Appellee US Airways Inc. This document will be SENT TO THE MERITS PANEL, if/when applicable. (NGL).
11/16/2011	PRECEDENTIAL OPINION Coram: SLOVITER, FUENTES and VANASKIE, Circuit Judges. Total Pages: 18. Judge: FUENTES Authoring (TMM)
11/16/2011	JUDGMENT, ORDERED and ADJUDGED by this Court that the judgment of the District Court entered on September 2, 2010, is hereby VACATED and the case is REMANDED. The parties shall each bear their own costs. (TMM)
11/28/2011	ECF FILER: UNOPPOSED Motion filed by Appellee US Airways Inc for Extension of Time to file Petition for panel rehearing/rehearing en banc until/for 12/14/2011. Certificate of Service dated 11/28/2011. (NGL)
12/08/2011	ORDER (Clerk) Motion for extension of time to file petition for rehearing is granted. Appellees petition for rehearing must be filed on or before 12/14/11, filed. (TMM)

DATE	PROCEEDINGS
12/14/2011	ECF FILER: Petition filed by Appellee US Airways Inc for Rehearing before original panel and the court en banc. Certificate of Service dated 12/14/2011. (NGL)
01/04/2012	ORDER (MCKEE, Chief Judge, SLOVITER, SCIRICA, RENDELL, AMBRO, FUENTES, SMITH, FISHER, CHAGARES, JORDAN, HARDIMAN, GREENAWAY JR. and VANASKIE, Circuit Judges) denying Petition for Rehearing filed by Appellee US Airways Inc, filed. Fuentes, Authoring Judge. (TMM)
01/12/2012	MANDATE ISSUED, filed. (TMM)

No. 2:08-CV-1593-DSC

US AIRWAYS, INC.,

Plaintiff,

V.

JAMES E. McCUTCHEN, and ROSEN LOUIK & PERRY, P.C.,

Defendants.

DOCKET ENTRIES

DATE	NO.	PROCEEDINGS
11/19/2008	1	COMPLAINT against JAMES E. MCCUTCHEN, ROSEN, LOUIK & PERRY, P.C. (Filing fee \$ 350 receipt number 1074221), filed by US AIRWAYS, INC. (Attachments: #1 Civil Cover Sheet, #2 Exhibit A, #3 Summons as to James E. McCutchen, #4 Summons as to Rosen, Louik & Perry, P.C.) (jv) (Entered: 11/19/2008)

11/19/2008		Summons Issued as to JAMES E. MCCUTCHEN, ROSEN, LOUIK & PERRY, P.C (jv) (Entered: 11/19/2008)
12/10/2008	8	ANSWER to 1 Complaint, by JAMES E. MCCUTCHEN, ROSEN, LOUIK & PERRY, P.C (Perry, Jon) (Entered: 12/10/2008)
08/20/2009	23	PRETRIAL STATEMENT by US AIRWAYS, INC (Paliotta, Shannon) (Entered: 08/20/2009)
09/21/2009	26	PRETRIAL STATEMENT by JAMES E. MCCUTCHEN, ROSEN, LOUIK & PERRY, P.C (Attachments: # 1 Exhibit Report & CV of Jon R. Perry, Esquire) (Rosen, Neil) (Entered: 09/21/2009)
10/30/2009	27	MOTION for Summary Judgment by US AIRWAYS, INC (Attachments: # 1 Proposed Order) (Paliotta, Shannon) (Entered: 10/30/2009)
10/30/2009	28	CONCISE STATEMENT OF MATERIAL FACTS In Support Of re <u>27</u> Motion for Summary Judgment by US AIRWAYS, INC (Paliotta, Shannon) (Entered: 10/30/2009)

10/30/2009	29	BRIEF in Support re <u>27</u> Motion for Summary Judgment filed by US AIRWAYS, INC (Paliotta, Shannon) (Entered: 10/30/2009)
10/30/2009	30	Appendix to 27 Motion for Summary Judgment by US AIRWAYS, INC (Attachments: # 1 Exhibit 1, # 2 Exhibit 1 to Appx. Ex. 1, # 3 Exhibit 2, # 4 Exhibit 3, # 5 Exhibit 4, # 6 Exhibit 5) (Paliotta, Shannon) (Entered: 10/30/2009)
12/04/2009	33	BRIEF in Opposition re <u>27</u> Motion for Summary Judgment filed by JAMES E. MCCUTCHEN, ROSEN, LOUIK & PERRY, P.C (Rosen, Neil) (Entered: 12/04/2009)
12/04/2009	34	Responsive CONCISE STATEMENT OF MATERIAL FACTS re 27 Motion for Summary Judgment by JAMES E. MCCUTCHEN, ROSEN, LOUIK & PERRY, P.C (Rosen, Neil) (Entered: 12/04/2009)

12/04/2009	35	Appendix to 34 Concise Statement of Material Facts by JAMES E. MCCUTCHEN, ROSEN, LOUIK & PERRY, P.C (Attachments: #1 Exhibit Affidavit of Jon R. Perry, Esquire, #2 Exhibit Expert Report of Jon R. Perry, Esquire) (Rosen, Neil) (Entered: 12/04/2009)
12/18/2009	36	REPLY to Response to Motion re 33 Brief in Support of 27 Motion for Summary Judgment filed by US AIRWAYS, INC. (Paliotta, Shannon) (Entered: 12/18/2009)
12/18/2009	37	REPLY to <u>34</u> Concise Statement of Material Facts, filed by US AIRWAYS, INC (Paliotta, Shannon) (Entered: 12/18/2009)
08/30/2010	38	MEMORANDUM OPINION granting motion for summary judgment filed on behalf of US Airways, Inc. Signed by Judge David S. Cercone on 8/30/10. (jmc) (Entered: 08/30/2010)

08/30/2010

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ORDER granting 27 Motion for Summary Judgment. US Airways. Inc. is entitled to an equitable lien by agreement or constructive trust over \$66,865.82, consisting of medical benefits paid to Defendant James E McCutchen by the US Airways, Inc. Employee Benefits Plan. Judgment is entered in favor of Plaintiff, US Airways, Inc., and against Defendants, James E. McCutchen and the law firm of Rosen, Louik and Perry, PC. The Clerk shall mark this case closed. Signed by Judge David S. Cercone on 8/30/10. (imc) (Entered: 08/30/2010)

09/02/2010

ORDER entering JUDGMENT in 40 favor of plaintiff US AIRWAYS, INC. and against defendant ROSEN, LOUIK & PERRY, P.C. in the amount of \$41,500.00, which represents the amount held in the firm's trust account for any lien against defendant McCutchen, and entering further JUDGMENT in favor of plaintiff US AIRWAYS. INC. and against defendant JAMES E. McCUTCHEN in the amount of \$25,365.82. Total amount of judgment in favor of plaintiff US AIRWAYS, INC. is \$66,865.82. Signed by Judge David S. Cercone on 9/2/10. (nit) (Entered: 09/02/2010)

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09/20/2010

NOTICE OF APPEAL as to 40 Judgment, 39 Order on Motion for Summary Judgment, 38 Memorandum & Opinion by JAMES E. MCCUTCHEN. ROSEN, LOUIK & PERRY, P.C., Filing fee \$455, receipt number 0315-1726526. Motion for IFP N/A. Certificate of Appealability N/A. Court Reporter(s): N/A. The Clerk's Office hereby certifies the record and the docket sheet available through ECF to be the certified list in lieu of the record and/or the certified copy of the docket entries. The Transcript Purchase Order form will NOT be mailed to the parties. The form is available on the Court's internet site. (Perry, Jon) (Entered: 09/20/2010)

11/16/2011

ORDERED and ADJUDGED by this Court that the judgment of the District Court entered on September 2, 2010, is hereby VACATED and the case is REMANDED. The parties shall each bear their own costs.

Mandate will follow. (Entered: 11/16/2011)

- 01/04/2012 46 ORDER of USCA as to <u>42</u> Notice of Appeal, denying rehearing filed in their court. (jv) (Entered: 01/04/2012)
- 01/12/2012 47 MANDATE of USCA issued
 Vacating the 40 Order entered
 9/2/20 and remanding. The parties
 shall each bear their own costs.
 (Attachments: # 1 mandate letter,
 # 2 opinion) (jv) (Entered:
 01/12/2012)
- 08/14/2012 49 ORDER STAYING CASE directing that the case is stayed pending resolution of the appeal to the United States Supreme Court. Signed by Judge David S. Cercone on 8/14/12. (njt) (Entered: 08/14/2012)

CIVIL ACTION NO. 2:08-cv-01593

US AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the US Airways, Inc. Employee Benefits Plan,

Plaintiff,

V.

JAMES E. McCUTCHEN, and ROSEN, LOUIK & PERRY, P.C.,

Defendants.

District Judge: David S. CERCONE

PLAINTIFFS CONCISE STATEMENT OF UNDISPUTED MATERIAL FACTS IN SUPPORT OF PLAINTIFFS MOTION FOR SUMMARY JUDGMENT

Plaintiff US Airways, Inc., in its capacity as fiduciary and administrator of the US Airways, Inc. Health Benefit Plan, through its undersigned counsel, and pursuant to Local Rule 56.1 of the Local Rules of the United States District Court for the Western District of Pennsylvania, hereby files its Concise Statement of Undisputed Material Facts in support of its Motion for Summary Judgment.

A. The Parties

- 1. Plaintiff sponsors and is a fiduciary of the U.S. Airways Inc. Health Benefit Plan. (App. Ex. 1, Shanahan Dec. at ¶ 2).
- 2. The Plan provides medical expense benefits to its participants and beneficiaries, and is entirely self-funded by US Airways through its general assets. (App. Ex. 1; Shanahan Dec. at ¶ 3, Ex. 1 at p. 93).
- 3. Defendant James E. McCutchen was, at all relevant times, a beneficiary under the terms of the Plan, and Defendant Rosen, Louik & Perry is counsel to McCutchen and holds certain funds in trust that are the subject of this action. (App. Ex. 3 at ¶¶ 5-6).
 - B. Defendant McCutchen Suffers Injuries in an Automobile Accident and the Plan Pays Related Medical Expenses on his Behalf that Defendants Refuse to Reimburse
- 4. On January 24, 2007, McCutchen was involved in a three car motor vehicle accident, in which he sustained multiple physical injuries ("Accident"). (App. Ex. 3 at ¶ 11).
- 5. The Plan paid accident-related medical expenses on McCutchen's behalf, totaling \$66,865.82.1 (App. Ex. 5; Johnson Dec. at ¶ 3, Ex. 1).
- 6. Following the Accident, McCutchen retained the services of Defendant Rosen Louik & Perry, P.C. to pursue claims relating to the accident. (App. Ex. 3 at ¶ 14).

¹ There was a typographical error in Paragraph 12 of Plaintiff's Complaint reflecting that the Plan paid medical expenses in the amount of \$68,865.82. However, the correct total amount paid by the plan was \$66,865.82 as stated in Paragraph 21 of the Complaint.

- 7. Plaintiff on behalf of the Plan, retained Ingenix Subrogation Services to pursue recovery of the benefit payments the Plan made to McCutchen, relating to the January 24, 2007 accident. (App. Ex. 1, Shanahan Dec. at ¶ 6). Plaintiff, through Ingenix, sought reimbursement out of a potential Accident-related recovery, corresponding to the amount of benefits the Plan paid on McCutchen's behalf. (App. Ex. 3 at ¶ 17; App. Ex. 5; Johnson Dec. at 114, Ex. 1).
- 8. On June 26, 2007, the Plan placed Defendants on notice of a potential lien against recovery McCutchen might have relating to the accident. (App. Ex. 5; Johnson Dec. at ¶ 4).
- 9. On June 16, 2008, McCutchen, through his counsel, denied the Plan's right to reimbursement out of any potential Underinsured Motorist proceeds. (App. Ex. 5; Johnson Dec. at ¶ 5).
- 10. In response, throughout early July and August, 2008, the Plan and McCutchen's counsel, Jon Perry, communicated regarding the Plan's potential reimbursement rights, and Defendants' denial of same. (App. Ex. 5; Johnson Dec. at ¶ 6).
- 11. In August 2008, McCutchen executed a Release of All Claims against Battisti in exchange for \$10,000.00 as a full and final settlement of his bodily injuries suffered in the January 24, 2007 accident ("Lawsuit Settlement"). (App. Ex. 3 at ¶ 16; App. Ex. 4, p. 2).
- 12. In September 2008, McCutchen executed a Release and Trust Agreement with Grange Mutual Casualty and Grange Insurance Companies in exchange for \$100,000.00 as a full and final

- settlement of his uninsured/underinsured motorist claim with his insurance company ("UIM Claim"). (App. Ex. 3 at ¶¶ 15-16; App. Ex. 4, p. 2).
- 13. McCutchen refused to reimburse the plan, denied his obligation to do so, and an amount of \$41,500.00, consisting of a portion of the UIM and Lawsuit settlement proceeds was placed in a trust account maintained by Rosen Louik & Perry, P.C. (App. Ex. 3 at ¶¶ 17-18; App. Ex. 4, p. 2).
- 14. Rosen took 40% of the \$110,000.00 as attorney's fees. (App. Ex. 4, p. 2).
- 15. McCutchen is in possession of the balance of the funds belonging to the Plan, from which an amount of \$25,365.82, represents benefits paid by the Plan on behalf of McCutchen for treatment of injuries relating to the Accident. (App. Ex. 2 at ¶¶ 18-19).

C. Relevant SPD Provisions

- 16. The Plan, through its SPD, provides that it shall have subrogation and reimbursement rights to recover benefits the Plan provides to covered persons for claims incurred "as a result of negligence, willful misconduct, or other actions of a third party." (App. Ex. 2, Ex. A).
- 17. The Plan requires participants such as McCutchen, to "reimburse the Plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, a beneficiary's own insurance company as the result "judgment, award, settlement, or otherwise." (Id.).
- 18. The SPD further provides that, the beneficiary is required "to assist the administrator of the Plan in enforcing these rights and may not negotiate any

agreements with a third party that would undermine the subrogation rights of the Plan." (Id.).

19. The SPD further provides that the Plan administrator has "the sole discretion to determine all matters relating to interpretation and operation of the Plan" and that "Any determination by the Plan administrator, or its authorized delegate, shall be final and binding." (App. Ex. 1; Shanahan Dec., Ex. 1, p. 91)

D. Defendants' Position

- 20. Defendants claim that any reimbursement should be reduced because McCutchen was, as they argue, not "made whole" by his recovery. (App. Ex. 3 at ¶ 33; App. Ex. 4, pp. 4-5).
- 21. Defendants also allege that their attorney's fees should be deducted out of the settlement monies prior to reimbursement. (App. Ex. 3 at ¶ 31).
- 22. Defendants further argue for a "substantial" reduction in the reimbursement amounts because McCutchen's damages exceeded his recovery. (App. Ex. 3 at ¶ 32).
- 23. Defendants have asserted that the UIM settlement cannot be subject to a reimbursement claim because it is not "monies recovered from a third party." (App. Ex. 4, pp. 5-6).
- 24. Defendants admit that, in addition to the fund received in the Lawsuit Settlement, McCutchen also received \$100,000.00 from an Underinsured Motorist Carrier ("UIM") settlement, but contend that the Plan's subrogation/reimbursement claims do not apply to the UIM settlement because it is not a "third party." (App. Ex. 3 at ¶ 13; App. Ex. 4, pp. 5-6).

Respectfully submitted,

/s/ Shannon H. Paliotta

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Attorneys for Plaintiff US Airways, Inc.

October 30, 2009

US AIRWAYS HEALTH BENEFIT PLAN FOR EMPLOYEES

SUMMARY PLAN DESCRIPTION EFFECTIVE MAY 1, 2003

ADDITIONAL RULES THAT APPLY TO THE PLAN

Subrogation and Right of Reimbursement

The purpose of the Plan is to provide coverage for qualified expenses that are not covered by a third party. If the Plan pays benefits for any claim you incur as the result of negligence, willful misconduct, or other actions of a third party, the Plan will be subrogated to all your rights of recovery. You will be required to reimburse the Plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, your own insurance company as the result of judgment, settlement, or otherwise. In addition, you will be required to assist the administrator of the Plan in enforcing these rights and may not negotiate any agreements with a third party that would undermine the subrogation rights of the Plan.

US AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the US Airways, Inc. Employee Benefits Plan,

Plaintiff,

v.

JAMES E. McCUTCHEN, and ROSEN, LOUIK & PERRY, P.C.,

Defendants.

COMPLAINT

Plaintiff US Airways, Inc., in its capacity as fiduciary and administrator of the US Airways, Inc. Health Benefit Plan, submits this Complaint against Defendants James E. McCutchen ("McCutchen") and Rosen, Louik, & Perry, P.C. ("Rosen"), as follows:

NATURE OF ACTION

1. This is an action under Section 502(a)(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1132(a)(3), for equitable relief to remedy McCutchen's violations of the terms of the US Airways, Inc. Health Benefit Plan (the "Plan"). Plaintiff seeks equitable relief in the form of a constructive trust or equitable lien upon amounts held by Rosen, on behalf of McCutchen, that belong to the Plan, in accordance

with ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), and upon amounts held by McCutchen.

JURISDICTION

2. This Court has original and exclusive jurisdiction over Plaintiff's claims for relief pursuant to ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1).

VENUE

3. Venue is proper pursuant to ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2), of ERISA because Rosen resides in this judicial district and because, on information and belief, some of the funds at issue are being held in this judicial district.

PARTIES

- 4. Plaintiff US Airways, Inc. ("US Airways") sponsors and is a fiduciary of the Plan. US Airways' principal place of business is located 2345 Crystal Drive, Arlington, Virginia, 22227. The Plan is an employee welfare benefit plan within the meaning of ERISA § 3(1), 29 U.S.C. § 1002(1).
- 5. McCutchen is a citizen of Columbiana County, Ohio, and resides at 48211 Moore Road, East Liverpool, Ohio 43920. At all times relevant hereto, McCutchen was a participant or beneficiary in the Plan.
- 6. Rosen is a law firm located at 437 Grant Street, Suite 200, Pittsburgh, Pennsylvania 15219. Rosen is counsel to McCutchen and holds certain funds in trust that are the subject of this action.

FACTUAL BACKGROUND

7. The Plan provides health benefits to eligible US Airways employees and their dependants. The Plan is self-funded by US Airways through its

general assets. Benefits provided under the Plan are contained within a Summary Plan Description ("SPD"). A true and correct copy of the relevant excerpts from the SPD is attached as Exhibit A to this Complaint.

- 8. The SPD provides that the Plan shall have subrogation and reimbursement rights to recover benefits the Plan provides to covered persons for claims incurred "as a result of negligence, willful misconduct, or other actions of a third party." Ex. A., p. 72.
- 9. The SPD requires covered persons to "reimburse the Plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, [the covered person's] own insurance company as result of judgment, settlement, or otherwise." Ex. A., p. 72.
- 10. The SPD provides that covered persons are required "to assist the administrator of the Plan in enforcing these [subrogation] rights and may not negotiate any agreements with a third party that would undermine the subrogation rights of the Plan." Ex. A, p. 72.
- 11. On January 24, 2007 McCutchen sustained injuries in an automobile accident (the "Accident").
- 12. The Plan paid medical expenses of \$68,865.82 on behalf of McCutchen for treatment of the injuries he sustained as a result of the Accident.
- 13. The Plan paid the benefits referenced in the paragraph above, and McCutchen accepted them, under the express condition that McCutchen reimburse the Plan, to the extent of benefits paid, out of any monies McCutchen recovered from a third

party, including, but not limited to, his own insurance company as result of judgment, settlement, or otherwise.

- 14. McCutchen retained the services of Rosen to pursue claims relating to the Accident.
- 15. Upon information and belief, McCutchen also filed a claim for underinsured motorist benefits.
- 16. Plaintiff is informed and believes that McCutchen received a settlement in the amount of \$110,000 pertaining to his claims, and that \$100,000 of these monies pertained to McCutchen's underinsured motorist claim.
- 17. Despite repeated demands, McCutchen has refused to reimburse the Plan out of the funds he received in settlement of his claims.
- 18. The amount of \$41,500, consisting of a portion of the settlement proceeds, has been placed in a trust account maintained by Rosen.
- 19. Upon information and belief, McCutchen is in possession of the balance of the funds belonging to the Plan, in the amount of \$27,365.82, representing benefits paid by the Plan on behalf of McCutchen for treatment of injuries relating to the Accident.

CLAIMS FOR RELIEF UNDER ERISA 502(a)(3).

- 20. Plaintiff re-states and re-alleges paragraphs 1-19 of the Complaint as if fully set forth herein.
- 21. The Plan has a right to reimbursement for the \$66,865.82 in medical benefits it paid on behalf of McCutchen as a result of the Accident.
- 22. McCutchen has refused to reimburse the Plan, in violation of the terms of the Plan.

- 23. McCutchen has been unjustly enriched by his refusal to reimburse the Plan for the medical benefits it paid on his behalf.
- 24. As a result of McCutchen's violation of the terms of the Plan, the Plan has been harmed and Plaintiff seeks all appropriate equitable relief, pursuant to ERISA § 502(a)(3), to enforce the terms of the Plan, including:
- (a) the imposition of a constructive trust or equitable lien in favor of the Plan upon the settlement proceeds identified herein, plus accumulated interest;
- (b) a declaration of the Plan's ownership of the above-referenced settlement proceeds up to the full amount of payments made by the Plan for McCutehen's medical expenses; and
- (c) an order directing the Rosen law firm and McCutchen, respectively, to pay or turn over such settlement proceeds, plus accumulated interest, to the Plan to the extent of its interest therein.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff requests that the Court enter a Judgment and Order in its favor:

- (a) the imposition of a constructive trust or equitable lien in favor of the Plan upon the settlement proceeds identified herein, plus accumulated interest;
- (b) a declaration of the Plan's ownership of the above-referenced settlement proceeds up to the full amount of payments made by the Plan for McCutchen's medical expenses; and

- (c) an order directing Rosen, Louik & Perry, P.C. and James E. McCutchen to pay or turn over such settlement proceeds, plus accumulated interest, to the Plan to the extent of its interest therein.
- (d) ordering Defendants to pay Plaintiff's reasonable costs and attorney's fees incurred in connection with this action; and
- (e) any other relief the Court deems just and equitable.

Respectfully submitted,

/s/ Shannon H. Paliotta
Shannon Huygens Paliotta,
(PA #91000)
LITTLER MENDELSON, P.C.
625 Liberty Avenue - 26th Floor
Pittsburgh, PA 15222
(412) 201-7600 Phone
(412) 456-2377 Fax
Attorneys for Plaintiff
US Airways, Inc.

CIVIL ACTION NO. 2:08-cv-01593

US AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the US Airways, Inc. Employee Benefits Plan,

Plaintiff,

V.

JAMES E. McCUTCHEN, and ROSEN, LOUIK & PERRY, P.C.,

Defendants.

District Judge: David S. CERCONE

DEFENDANTS' ANSWER AND AFFIRMATIVE DEFENSES

- 1. The allegations contained in paragraph 1 are conclusions of law that require no response. To the extent a response may be required, it is admitted that Plaintiff asserts that it is filing this action under Section 502(a)(3) of ERISA, seeking equitable relief in the form of a constructive trust or equitable lien; however, it is denied that this matter is within the jurisdiction of ERISA and that Plaintiff is entitled to the relief it seeks.
- 2. The allegations contained in paragraph 2 are conclusions of law that require no response. To the

extent that a response may be required, the allegations are denied.

- 3. The allegations contained in paragraph 3 are conclusions of law that require no response. To the extent that a response may be required, it is admitted that Rosen resides in and is holding funds in this judicial district but it is denied that venue is proper within this judicial district.
- 4. Defendants lack sufficient information to admit or deny the allegations contained in paragraph 4.
- 5. The allegations contained in paragraph 5 are admitted.
- 6. The allegations contained in paragraph 6 are admitted.
- 7. To the extent that the allegations contained in paragraph 7 refer to a writing, that writing speaks for itself. Otherwise, Defendants lack sufficient information to admit or deny the remaining allegations.
- 8. The allegations contained in paragraph 8 refer to a writing that speaks for itself.
- 9. The allegations contained in paragraph 9 refer to a writing that speaks for itself.
- 10. The allegations contained in paragraph 10 refer to a writing that speaks for itself.
- 11. The allegation contained in paragraph 11 are admitted.
- 12. It is admitted that the Plan paid for medical expenses incurred by McCutchen, but Defendants lack sufficient information to admit or deny the precise amount of money that the Plan spent for such

medical expenses. Further, not all of the medical expenses paid by the Plan were related to the accident of January 24, 2007 and strict proof is demanded.

- 13. The allegations contained in paragraph 13 are conclusions of law that require no response. To the extent that a response may be required, it is specifically denied that monies recovered from McCutchen's underinsurance carrier constitute recovery from a "third party." It is also denied that McCutchen accepted benefits under any express conditions.
- 14. The allegations contained in paragraph 14 are admitted.
- 15. The allegations contained in paragraph 15 are admitted.
- 16. The allegations contained in paragraph 16 are admitted.
- 17. It is admitted that Defendants have refused to reimburse the Plan out of the settlement funds but it is specifically denied that the Plan is entitled to any reimbursement.
- 18. The allegations contained in paragraph 18 are admitted.
- 19. It is specifically denied that any balance exists to which the Plan is entitled. Even if the Plan is entitled to reimbursement, which Defendants continue to deny, it is Defendant Rosen that created the fund for which it is entitled to a fee. As a result, the funds placed in Rosen's trust account are the maximum amount of reimbursement to which the Plan is entitled.

- 20. The allegations contained in paragraph 20 merely restate prior allegation to which Defendants have responded above,
- 21. The allegations contained in paragraph 21 are conclusions of law that require no response. To the extent that a response may be required, it is denied that the Plan is entitled to reimbursement.
- 22. The allegations contained in paragraph 22 are conclusions of law that require no response. To the extent that a response may be required, it is admitted that Defendants have refused to reimburse the Plan but it is denied that the Plan is entitled to reimbursement.
- 23. The allegations contained in paragraph 23 are conclusions of law that require no response. To the extent that a response may be required, it is denied that the Plan is entitled to reimbursement. It is further denied that McCutchen has been unjustly enriched.
- 24. It is denied that Plaintiff is entitled to any of the relief alleged in paragraph 24. By way of further response, it is specifically denied that Defendants can be, under any circumstances, be required to pay Plaintiff's attorney fees in connection with this action.

WHEREFORE, Defendants demand that judgment be entered in their favor and against Plaintiff, together with costs.

AFFIRMATIVE DEFENSES

- 25. Plaintiff's Complaint fails to state claims upon which relief can be granted.
- 26. This Honorable Court lacks jurisdiction to hear this controversy.

- 27. Plaintiff lacks standing to bring this action.
- 28. Over the entire course of time that Defendants were handling and ultimately resolving the underlying claims that resulted in the recovery of the settlement funds, Plaintiff acted in such a manner that it is estopped from pursuing this action.
- 29. Plaintiff is guilty of laches, thus preventing it from recovering on this claim.
- Plaintiff is guilty of waiver, thus preventing it from recovering on this claim.
- 31. Even if Plaintiff is entitled to reimbursement, it is required to reduce its claim by the amount of Defendant Rosen's attorney fees for generating the recovery.
- 32. In addition to a reduction for attorney fees, the damages incurred by Defendant McCutchen so far exceed the amount of his recovery that Plaintiff's claim for reimbursement must be further substantially reduced.
- 33. Defendant McCutchen has not been made whole by the recovery in the underlying case and Plaintiff is not entitled to any portion of the settlement funds recovered.
- 34. Plaintiff has breached its fiduciary duty owed to Defendant McCutchen by its unreasonable interpretation of provisions of the Plan.

WHEREFORE, Defendants demand that judgment be entered in their favor and against Plaintiff, together with costs.

JURY TRIAL DEMANDED.

/s/ Jon R. Perry
Jon R. Perry, Esq.
(PA #62451)

ROSEN LOUIK & PERRY, P.C.
437 Grant Street, Suite 200
Pittsburgh, PA 15219
(412) 281-4200 Phone
(412) 281-2997 Fax

Attorney for Defendants

CIVIL ACTION NO. 2:08-cv-01593

US AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the US Airways, Inc. Employee Benefits Plan,

Plaintiff,

V

JAMES E. McCUTCHEN, and ROSEN, LOUIK & PERRY, P.C.,

Defendants.

Judge: David S. CERCONE

DECLARATION OF DONNA JOHNSON

- I, Donna Johnson, declare as follows:
- 1. I am currently employed by Ingenix Subrogation Services as a Business Manager. In that role, my job responsibilities include managing and supervising benefit recovery claims for UnitedHealth Group and other administrated health benefit plans.
- 2. In the course of my job duties, I became aware that Ingenix had been retained by the claims administrator of the U.S. Airways Inc. Health Benefit Plan (the "Plan") to pursue recovery of medical benefit payments made to James E. McCutchen, a participant

in the Plan, from amounts McCutchen received from third parties relating to injuries he suffered in an automobile accident on or around January 24, 2007.

- 3. As part of my job duties and responsibilities, I am familiar with records maintained in Ingenix's ordinary course of business. Exhibit 1 to this Declaration is a true and correct copy of a "Medical Fayment Summary" reflecting amounts the Plan paid on McCutchen's behalf, (\$66,865.82) which pertain to injuries he suffered as a result of the Accident.
- 4. On or around June 26, 2007, Ingenix placed McCutchen's counsel, Rosen Louik & Perry, P.C. on notice of the Plan's potential lien on any recovery McCutchen may obtain relating to the January 24, 2007 accident. From that date forward, Ingenix continued to correspond with McCutchen's counsel regarding the Plan's right to reimbursement and the status of the underlying tort claims.
- 5. On June 16, 2008, McCutchen, through his counsel, denied that the Plan had any right to reimbursement out of any recovery McCutchen might obtain, including, but not limited to any Underinsured Motorist carrier proceeds.
- 6. On several occasions during July and August, 2008, the Plan and McCutchen's counsel, Jon Perry, communicated regarding the Plan's potential reimbursement rights, and McCutchen's position that he was not obligated to make such reimbursement.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: October 28, 2009

/s/ Donna Johnson Donna Johnson

CIVIL ACTION NO. 2:08-cv-01593

US AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the US Airways, Inc. Employee Benefits Plan,

Plaintiff,

V.

JAMES E. McCUTCHEN, and ROSEN, LOUIK & PERRY, P.C.,

Defendants.

District Judge: David S. CERCONE

DEFENDANTS' RESPONSIVE CONCISE STATEMENT OF MATERIAL FACTS IN OPPOSITION TO PLAINTIFFS MOTION FOR SUMMARY JUDGMENT

Defendants, JAMES E. McCUTCHEN and ROSEN LOUIK & PERRY, P.C., by and through their undersigned counsel file their Responsive Concise Statement of Material facts in Opposition to Plaintiff's Motion for Summary Judgment pursuant to Local Rule 56.1 of the United States District Court for the Western District of Pennsylvania, and this Court's Scheduling Order.

1. Admitted.

- 2. Defendants deny that it is undisputed that the Plan is entirely self-funded. First, the only proof Plaintiffs have offered Defendants on this point is an IRS Form 5500 for the calendar year 2005 (DA, Ex. 1, pp. 4-5)1, yet this accident occurred in 2007. Furthermore, since Mr. McCutchen was injured and obtained representation from Defendant Rosen Louik & Perry ("Defendant Law Firm") and throughout this litigation. Plaintiff has provided Defendants with information that Mr. McCutchen was a beneficiary of two separate and different plans (DA, Ex. 1, pp. 1, 3-10, 19-20, 23-29), one of which uses insurance for partial funding (DA, Ex. 1, pp.9-10). Because a nonentirely self-funded plan can recover nothing under Pennsylvania law. Plaintiff must be required to prove that it is entirely self-funded.
- 3. Defendants deny that it is undisputed that Mr. McCutchen was a beneficiary of the US Airways plan. Since Mr. McCutchen was injured and obtained representation from Defendant Law Firm and throughout this litigation, Plaintiff has provided Defendants with information that Mr. McCutchen was a beneficiary of two separate and different plans (DA, Ex. 1, pp. 1, 3-10, 19-20, 23-29).
 - 4. Admitted.
- 5. Although Defendants are not certain that all of the medical expenses are related to the accident, they do admit that a majority of those expenses are related.

¹ This designation is used to refer to the correspondingly number Exhibit of Defendant Appendix of Record Evidence. The designation "p." or "pp." refers to the numbered pages of documents attached as exhibits to Exhibit 1 of Defendants Appendix, Mr. Perry's Affidavit.

6-14. Admitted.

- 15. As a matter of law, any funds distributed to the Mr. McCutchen do not belong to the Plan. Moreover, it denied that Mr. McCutchen is in possession of those funds because that money has been spent.
- 16-19. It is admitted that Plaintiff's quotations in these paragraphs of certain provisions of the Plan's SPD are accurate.
- 20-24. Plaintiff's summary of Defendants' positions in these paragraphs is correct, yet incomplete. Defendants also assert that summary judgment is inappropriate because (1) a factual dispute exists as to whether Mr. McCutchen was covered by the US Airways plan, (2) a factual dispute exists as to whether the US Airways plan is entirely self-funded, (3) Plaintiff has waived its right to, and/or is estopped from, asserting its lien, (4) in certain regards, Plaintiff is not seeking "appropriate" equitable relief, and (5) Plaintiff's maximum recover, if any, is limited to the funds being held in escrow by Defendant Law Firm.

Other Material Facts Necessary to Rule on Summary Judgment Motion

- 25. The \$110,000 that Mr. McCutchen recovered constituted all of the available insurance coverage applicable to his automobile accident (DA, Ex. 1, ¶¶ 5, 7, 10-11).
- 26. For the purposes of this summary judgment motion, it must be assumed to be true that the actual value of Mr. McCutchen's case was somewhere between \$1,000,000 and \$1,750,000 (DA, Ex. 2).
- 27. When Mr. Perry was attempting to settle Mr. McCutchen's third party case, he requested

Plaintiff's approval for entering into the settlement, yet Plaintiff failed to cooperate, requiring Mr. Perry to act unilaterally (DA, Ex. 1, ¶¶ 5-7, 10).

Respectfully submitted, ROSEN LOUIK & PERRY, P.C.

By: /s/ Neil R. Rosen
Neil R. Rosen, Esquire
Pa. I.D. 23619
200 The Frick Building
437 Grant Street
Pittsburgh, PA 15219
Phone: (412) 281-4200
Fax: (412) 281-2997
E-Mail: nrosen@
caringlawyers.com

Attorneys for Defendants

CIVIL ACTION NO. 2:08-cv-01593

US AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the US Airways, Inc. Employee Benefits Plan,

Plaintiff,

V.

JAMES E. McCUTCHEN, and ROSEN, LOUIK & PERRY, P.C.,

Defendants.

District Judge: David S. CERCONE

AFFIDAVIT OF JON R. PERRY, ESQUIRE

Before me, the undersigned Notary Public, this day, personally, appeared, JON R. PERRY, ESQUIRE, to me known, who being duly sworn according to law, deposes the following:

- I, Jon R. Perry, Esquire, am a member of the law firm of Rosen Louik & Perry, Esquire.
- 2. I represented James E. McCutchen and his wife, Janet McCutchen, after Mr. McCutchen was injured in an automobile accident on January 24, 2007.

- 3. The accident occurred when a vehicle driven by Michelle Battisti southbound on State Route 60 in Beaver County left the roadway, crossed the median, entered the northbound lane of travel, and struck Mr. McCutchen's vehicle, which was then struck by another vehicle that was traveling behind the McCutchen vehicle.
- 4. In addition to Mr. McCutchen's injuries, Chelsea Roman, an occupant of the Battisti vehicle was killed, and two other fellow occupants, John Filippi and Jessica Saska suffered traumatic brain injuries.
- 5. Ms. Battisti had only \$100,000 in total coverage for the accident.
- Because no questions concerning liability existed, the lawyers for the four injured individuals were required to allocate the limited insurance proceeds.
- 7. It was eventually proposed that proceeds should be distributed as follows: (1) \$35,000 to the Estate of Chelsea Roman; (2) \$35,000 to John Filippi (who, at the time of the proposal, had yet to regain consciousness since the accident); (3) \$20,000 to Jessica Saska, and; (4) \$10,000 to Mr. McCutchen.
- 8. I learned that Mr. McCutchen's health insurer had hired Ingenix to assist in asserting a lien against any recovery for accident-related medical expenses it had paid; thereafter I corresponded with Ingenix as well as attorneys representing Plaintiff in this action concerning the potential lien.
- 9. Attached hereto are copies of letters between me, Ingenix, and Plaintiffs' attorneys as well as copies of relevant pages of enclosures in those letters

(the documents are attached as exhibits and are numbered 1-29).

- 10. I informed Ingenix of the settlement proposal set forth in paragraph 7 above and asked for approval of the settlement terms and waiver of the lien. When Ingenix failed to respond in any way, I agreed to the proposal and the case against Ms. Battisti was settled on those terms.
- 11. Thereafter, I assisted the McCutchens in recovering \$100,000 in underinsured motorist benefits, the policy limits of that coverage.
- 12. I was never informed by any representative of Ingenix how it learned of the settlement of the McCutchens' underinsured motorist claim.
- 13. Despite numerous requests, Ingenix never produced reliable documentation establishing the validity and applicability of a self-funded ERISA plan and never proved what medical expenses it paid that were causally related to the accident.

/s/ Jon R. Perry Jon R. Perry

INGENIX

1215 Technology Drive Eden Prairie, MN 55344

June 26, 2007

VIA FACSIMILE & U.S. MAIL

Rosen, Louik & Perry Jon Perry THE FRICK BUILDIGN STE 200 437 GRANT STREET PITTSBURGH, PA 15219

RE: Injured Party: James E. McCutchen

Date of Injury: 01/24/2007

Group: US AIRWAYS GROUP,

INC.

AMERICA WEST

#000704267

Our File #: 5952337

Dear Jon Perry.

This letter will formally notify you that UnitedHealthcare Services has retained Ingenix Subrogation Services to pursue a recovery for medical benefits that have been or may be paid by them on behalf of James E Mc Cutchen for the treatment of injuries sustained arising out of the above captioned injury. Please contact us prior to settlement to obtain the total amount of paid benefits.

The health plan is set up under the federal Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829, as amended, 29 U.S.C. § 1001 et seq.

Our client asserts a subrogation and/or reimbursement interest in this matter under applicable law. Please notify us immediately if you have already obtained a recovery from some other party. Once settlement funds come into your possession, you should hold them in trust until such time as our client's interest has been severed from the interest of your client.

Please contact me to discuss this matter. Also, please direct all future correspondence relating to our client's subrogation/reimbursement rights to my attention.

Thank you for your assistance.

Sincerely,

/s/ Michelle Hochstein Michelle Hochstein / KN Recovery Analyst Phone: 952-833-7060 Fax: 800-708-6526

ROSEN LOUIK & PERRY, P.C. ATTORNEYS AT LAW

June 26, 2007

Via Fax 1-800-708-6526

Michelle Hochstein/KN, Recovery Analyst Ingenix Subrogation Services MN002-0220 12125 Technology Drive Eden Prairie, MN 55344

Re: Our Client: JAMES McCUTCHEN

Group: US Airways Group, Inc.

American West #000704267

Your File #: 5952337 Date of Injury: 1/24/07

Dear Ms. Hochstein:

You have informed me that you believe that US Airways Group, Inc. American West #000704267 is entitled to the right of subrogation from any recovery made in the third party action because US Airways Group, Inc. American West #000704267 maintains a self-funded ERISA Plan. As you know, a "self-funded ERISA plan" is a term of art requiring that the employer must fund 100% of the Plan. To the extent that any insurance company money is involved, the plan would not qualify as self-funded for purposes of our discussion. Please confirm in writing that the fund is self-funded under this definition. Also, please supply me with the IRS Form 5500 as well as a

complete copy of the plan or trust document, or summary description.

Very truly yours, ROSEN LOUIK & PERRY, P.C.

By: /s/ Jon R. Perry Jon R. Perry

JRP/pdo

ROSEN LOUIK & PERRY, P.C. ATTORNEYS AT LAW

April 24, 2008

Via Fax 1-800-708-6526

Michelle Hochstein/KN, Recovery Analyst Ingenix Subrogation Services MN002-0220 12125 Technology Drive Eden Prairie, MN 55344

Re: Our Client: JAMES McCUTCHEN

Group: US Airways Group, Inc.

American West #000704267

Your File #: 5952337
Date of Injury: 1/24/07

Dear Ms. Hochstein:

Enclosed please find recent correspondence I received regarding James McCutchen's claim. As you are undoubtedly aware, the accident at issue in this case involved multiple claimants with a very limited amount of insurance possessed by the atfault driver. After numerous discussions with the lawyers representing the other claimants, a proposed breakdown of claims has been made. I enclose the most recent correspondence detailing the proposed payments. Frankly, I cannot really object to this breakdown.

Obviously, there will be inadequate proceeds to compensate Mr. McCutchen for the injuries he sustained in this accident. I am writing at this time to request a complete waiver of any lien that you may have. Please contact me immediately to discuss this claim.

Very truly yours,

ROSEN LOUIK & PERRY, P.C.

By: Jon R. Perry

JRP/pdo Enclosure

BOWERS ROSS & FAWCETT LLC ATTORNEYS AT LAW

April 17, 2008

Keith R. McMillen, Esquire McMillen Urick Tocci Fouse & Jones 2131 Brodhead Road Aliquippa, PA 15001

Dale M. Fouse, Esquire McMillen Urick Tocci Fouse & Jones 2131 Brodhead Road Aliquippa, PA 15001

Jon R. Perry, Esquire Rosen Louik & Perry, P.C. 437 Grant Street, Suite 200 Pittsburg, PA 15219

Re: Estate of Chelsea Roman, John P. Filippi, Jessica Saska and James McCutchen v. Battisti

D/A: 1/24/07

Dear Counsel:

I was recently supplied a brief summary of Mr. McCutchen's injuries and UIM coverage, and believe Keith McMillen's prior correspondence of November 13, 2007 sufficiently describes the Filippi, Roman, and Saska claims to permit settlement discussion of the Allstate 50/100 liability limits. I propose the following allocation, which I believe would be the most equitable under the difficult circumstances of these claims:

John Paul Filippi	\$35,000	
Estate of Chelsea Roman	\$35,000	
Jessica Saska	\$20,000	
James McCutcheon	\$10,000	

Please contact me to note your agreement with this proposal, as these claims are long overdue in being resolved.

Very truly yours,

/s/ Kenneth G. Fawcett

Kenneth G. Fawcett, Esquire

KGF/mjg

ROSEN LOUIK & PERRY, P.C. ATTORNEYS AT LAW

June 16, 2008

Via Fax 1-800-708-6526

Michelle Hochstein/KN, Recovery Analyst Ingenix Subrogation Services MN002-0220 12125 Technology Drive Eden Prairie, MN 55344

Re: Our Client: JAMES McCUTCHEN

Group: US Airways Group, Inc.

American West #000704267

Your File #: 5952337 Date of Injury: 1/24/07

Dear Ms. Hochstein:

Thank you for your telephone response to my April 28, 2008 letter. This is to confirm that you will be sending your client my request for a complete waiver of their lien in this matter because the \$10,000 proceeds are inadequate to compensate Mr. McCutchen for the injuries he sustained in this accident.

You also inquired as to any additional coverage available to Mr. McCutchen. This is to advise that under Pennsylvania law your client has no claim against the underinsured motorist policy.

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Very truly yours, ROSEN LOUIK & PERRY, P.C.

By: /s/ Jon R. Perry Jon R. Perry

JRP/pdo

ROSEN LOUIK & PERRY, P.C. ATTORNEYS AT LAW

July 3, 2008

Via Fax 1-800-708-6526 and First Class Mail

Michelle Hochstein/KN, Recovery Analyst Ingenix Subrogation Services MN002-0220 12125 Technology Drive Eden Prairie, MN 55344

Re: Our Client: JAMES McCUTCHEN

Group: US Airways Group, Inc.

American West #000704267

Your File #: 5952337 Date of Injury: 1/24/07

Dear Ms. Hochstein:

Enclosed please find a letter from other counsel involved in this matter. As you can see from the letter, they have now threatened to move to impose sanctions on me for the unreasonable delay in resolving this matter. This matter remains unresolved because you have failed to respond to my prior correspondence relating to your alleged lien. In light of your failure to respond and the threat of sanctions, I am taking your non-response as a complete and full waiver of your lien and I am consenting to resolve this case under the terms stated above.

53

Very truly yours, ROSEN LOUIK & PERRY, P.C.

By: /s/ Jon R. Perry/pdo Jon R. Perry

JRP/pdo

BOWERS ROSS & FAWCETT LLC ATTORNEYS AT LAW

July 1, 2008

Jon R. Perry, Esquire Rosen Louik & Perry, P.C. 437 Grant Street, Suite 200 Pittsburgh, PA 15219

Re: Estate of Chelsea Roman, John P. Fillippi, Jessica Saska and James McCutchen v.

Battisti

D/A: 1/24/07

Dear Mr. Perry:

On April 17, 2008, after receiving summaries of the injuries sustained by all of the Plaintiffs in this matter, I proposed the following distribution of the \$100,000.00 liability limits:

John Paul Filipi	\$35,000	
Estate of Chelsea Roman	\$35,000	
Jessica Saska	\$20,000	
James McCutcheon	\$10,000	

After receiving no response from you, I followed up with a letter on May 23, 2008, advising that all of the other parties have agreed to this allocation. I again requested your prompt attention in responding to the proposed allocation.

I believe that all counsel and their respective clients have been more than reasonable in providing you with ample opportunity to consult with your client and any other interested parties. It has been over one and one-half years since this accident occurred and we cannot prolong this decision any longer. Therefore, if we do not have a response from you within 10 days of the date of this letter, we will file Complaints in the Court of Common Pleas of Beaver County and will ask the Court to impose sanctions on you for the unreasonable delay in resolving this matter. Your immediate attention to this matter is required.

Sincerely,

/s/ Kenneth G. Fawcett

Kenneth G. Fawcett, Esquire

KGF/mjg

cc: Keith McMillen, Esquire

Dale Fouse, Esquire

ROSEN LOUIK & PERRY, P.C. ATTORNEYS AT LAW

July 14, 2008

Via Fax 1-800-708-6526 and First Class Mail

Michelle Hochstein/KN, Recovery Analyst Ingenix Subrogation Services MN002-0220 12125 Technology Drive Eden Prairie, MN 55344

Re: Our Client:

JAMES McCUTCHEN

Group:

US Airways Group, Inc.

American West #000704267

Your File #:

5952337

Date of Injury:

1/24/07

Dear Ms. Hochstein:

Due to Ingenix's persistent refusal to provide me with information in this matter, I was threatened with a Motion for Sanctions against me personally. To avoid sanctions, I resolved Mr. McCutchen's case for a payment of \$10,000. Please take action by July 19, 2008 if you believe your client is entitled to a portion of this recovery. If no action is taken, the settlement will be distributed.

It remains my position that no valid lien exists and, if a lien did exist, Ingenix waived the lien.

Very truly yours, ROSEN LOUIK & PERRY, P.C.

By: /s/ Jon R. Perry Jon R. Perry

JRP/pdo

ROSEN LOUIK & PERRY, P.C. ATTORNEYS AT LAW

October 7, 2008

Via Fax 1-800-708-6526

Michelle Hochstein/KN, Recovery Analyst Ingenix Subrogation Services MN002-0220 12125 Technology Drive Eden Prairie, MN 55344

RE: Our Client:

JAMES McCUTCHEN

Group:

US Airways Group, Inc.

American West #000704267

Your File #:

5952337

Date of Injury:

1/24/07

Dear Ms. Hochstein:

I am in receipt of your letter of October 6, 2008. Kindly inform me of the source for your notification that the underinsured motorist claim was settled. You have never been provided with an authorization to discuss this matter with anyone and I fear that your communications have violated my client's rights to privacy and confidentiality.

As previously discussed, I do not agree that United Health Care Services has a legitimate and enforceable lien in this matter. Mr. McCutchen suffered grievous injuries as a result of this auto accident and the third party and underinsured motorist recovery by no way make him whole and he is significantly under-compensated for his injuries. In this context, Pennsylvania law makes it clear that

healthcare providers do not have a right of subrogation. As such. United Healthcare Services' subrogation claim for repayment is denied. Additionally, as noted in prior correspondence to you I believe that your actions and inactions waived any right of subrogation and United Healthcare Services estopped from pursuing this Mr. McCutchen signed a contingent fee agreement providing me with a 40% fee in this case. Deducting my fee and a proportionate share of expenses from the recovery made in this case results in a balance of less than \$41,000 for any lien if such lien were valid. Accordingly, I will escrow \$41,500 in my IOLTA account

Please retain counsel and sue me and my firm directly because I will not release this amount until a Court of competent jurisdiction has ordered me to do so.

> Very truly yours, ROSEN LOUIK & PERRY, P.C.

By: /s/ Jon R. Perry Jon R. Perry

JRP/pdo

ROSEN LOUIK & PERRY, P.C. ATTORNEYS AT LAW

September 18, 2009

Neil R. Rosen, Esquire Rosen Louik & Perry Esquire 4327 Grant Street, Suite 200 Pittsburgh, PA 15219

Dear Mr. Rosen:

As the primary lawyer responsible for handling the claims of James and Janet McCutchen relating to an automobile accident that occurred on January 24, 2007, it was my opinion to a reasonable degree of legal certainty that the claims had a combined value of between \$1,000,000.00 and \$1,750,000.00. In reaching this determination I considered the accident report, the forensic evidence including damage to the vehicles, the eyewitness and witness statements, the medical records of the Plaintiffs, the social and economic backgrounds of Mr. and Mrs. McCutchen including work history, the age of Mr. McCutchen (51), and my personal evaluation of Mr. and Mrs. McCutchen.

The accident itself was of the most traumatic imaginable for Mr. McCutchen. At approximately 3:15 p.m. on a Wednesday afternoon, Mr. McCutchen was traveling north on SR 60, a four-lane divided highway, during daylight conditions. Mr. McCutchen witnessed a small sedan traveling in the southbound lane lose control, cross the median and approach his vehicle at a high rate of speed. Mr. McCutchen attempted to avoid impact but was

struck in a near head-on direction by the out-ofcontrol vehicle as it was spinning a in a clockwise direction backwards in his lane of travel. After impact, Mr. McCutchen's vehicle was also spun in a clockwise direction in part due to a second impact truck traveling from pickup Mr. McCutchen's vehicle. Impact and damage to the vehicles were extreme and extensive. Mr. McCutchen regained consciousness at the scene of the accident, and prior to being transported to Mercy Hospital in Pittsburgh, he learned that a 17year old high school student was dead in the back seat of the vehicle that struck him. In addition, a front seat passenger and the operator of the other vehicle were seriously injured and transported to General Hospital. Allegheny The injuries Mr. McCutchen suffered included a right bi-column acetabulum fracture, fracture of the posterior wall of the right acetabulum, a concussion and loss of consciousness for 30 minutes or less, a closed dislocation of his hip, extensive lacerations to his knee, leg and ankle, and neck and back injuries. Mr. McCutchen required a closed reduction for the dislocation of his hip, an open reduction surgical procedure with an internal fixation and a joint replacement of the acetabulum, and multiple sutures to his lacerations.

Mr. McCutchen had a history of 12 back surgeries and had an intrathecal infusion pump for medicated pain control. Unfortunately, as a result of this accident, his pain therapy was no longer effective and he suffered unrelenting and uncontrollable pain which continues to this day. Understandably, Mr. McCutchen suffered clinical depression

resulting from this accident and his uncontrolled pain.

Upon discharge, Mr. McCutchen was rendered disabled from his job with USAirways and was unable to return to work for 31/2 months. Despite 4 months of therapy, Mr. McCutchen was unable to eliminate the unremitting hip pain, he developed an antalgic gait with a very painful range of motion of his right hip. Radiographs revealed that posttraumatic arthritis had attacked his joints and he was required to have a total hip replacement which occurred on October 18, 2007. Mr. McCutchen was again forced to be off work for 5 months. Although the revision of the right total hip was successful from a surgical standpoint, Mr. McCutchen continues to suffer from severe chronic sciatica which causes disabling pain and has rendered him functionally disabled. Mr. McCutchen is unable to manage his residential property and has had to hire out all of that work. He can no longer golf, engage in his automotive body or engine repair work or do woodworking. He has little leg strength and walks with a terrible limp.

Mrs. McCutchen was forced to become her husband's caretaker and the relationship suffered greatly and continues to suffer due to the amount of pain that Mr. McCutchen experiences. Her loss of consortium claim is significant.

Very truly yours, ROSEN LOUIK & PERRY, P.C.

By: <u>/s/ Jon R. Perry</u> Jon R. Perry

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 2:08-cv-01593

US AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the US Airways, Inc. Employee Benefits Plan,

Plaintiff,

V.

JAMES E. McCUTCHEN, and ROSEN, LOUIK & PERRY, P.C.,

Defendants.

Judge: David S. CERCONE

PLAINTIFFS REPLY TO DEFENDANTS' RESPONSIVE STATEMENT OF UNDISPUTED MATERIAL FACTS IN OPPOSITION TO PLAINTIFFS MOTION FOR SUMMARY JUDGMENT

Plaintiff US Airways, Inc., in its capacity as fiduciary and administrator of the US Airways, Inc. Health Benefit Plan, through its undersigned counsel, and pursuant to Local Rule 56.1 of the Local Rules of the United States District Court for the Western District of Pennsylvania, hereby files its this Reply to Defendants' Responsive Concise Statement of Undisputed Material Facts in Opposition to Plaintiff's Motion for Summary

Judgment. Plaintiff replies only to those factual statements which Defendants have purported to dispute.

- 2. Defendants offered no facts or admissible evidence to dispute the Declaration of US Airways, Inc. Employee Benefits Plan Manager Kimie Shanahan that the Plan is entirely self-funded. (Shanahan Dec. ¶ 3, Ex. 1. p. 93).
- 3. Defendants have previously admitted that McCutchen was a participant or beneficiary under the Plan (Ans. ¶ 5) and offered no admissible evidence to rebut the Declarations of US Airways, Inc. Employee Benefits Plan Manager Shanahan and Ingenix representative Donna Johnson which confirm McCutchen's coverage under the US Airways Plan. (Shanahan Dec. ¶¶ 5-6; Johnson Dec. ¶ 2).
- 5. Defendants offer no evidence to dispute Plaintiff's assertion that the Plan paid \$68,865.82 in medical benefits on McCutchen's behalf, relating to injuries he suffered in a January 24, 2007 automobile incident. (Johnson Dec. ¶3, Ex. I).
- 15. Defendants offer no factual support for their denial of this paragraph.

Plaintiff's Response to Defendants' Statement of Additional Facts

- 25. This allegation is not properly supported by any factual material and is therefore denied. Further responding, this fact is not material to Plaintiff's motion for summary judgment.
- 26. Plaintiff denies that it "must be assumed true" that the actual value of McCutchen's case was somewhere between \$1,000,000 and \$1,750,000 and

further denies that such fact is material to Plaintiff's motion for summary judgment.

27. Denied. Plaintiff with communicated McCutchen's counsel throughout July and August 2008, and clearly refused to waive its lien on a the portion of potential settlement corresponding to benefits paid. Plaintiff did not "fail to respond" to Defendants' request for such waiver. which occurred on April 24, 2008, and June 16, 2008, to which Plaintiff responded on July 3, 2008. (Johnson Dec. ¶ 6; Perry Dec. Ex. I, pp. 11, 13, 16). Plaintiff further states that the fact asserted is immaterial to Plaintiff's motion for summary judgment.

Respectfully submitted,

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PETITIONER'S BRIEF

No. 11-1285

Supreme Court, U.S.

AUG 2 9 2012

OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

U.S. AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN.

Petitioner,

V.

JAMES MCCUTCHEN and ROSEN, LOUIK & PERRY, P.C.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF FOR PETITIONER

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QUESTION PRESENTED

Employee benefit plans often cover a participant's medical bills in the event of injury but require that, if the participant obtains compensation from a third party for that injury, he or she reimburse the plan in full. Under Section 502(a)(3) of the Employee Retirement Income Security Act (ERISA), plans may enforce these reimbursement provisions in court by seeking "appropriate equitable relief" to "enforce * * * the terms of the plan." 29 U.S.C. § 1132(a)(3).

The question presented is: Whether ERISA Section 502(a)(3) authorizes courts to use equitable principles to rewrite contractual language, and refuse to order participants to reimburse their plan for benefits paid, even where the plan's terms give it the right to full reimbursement.

PARTIES TO THE PROCEEDINGS

The following were parties to the proceedings in the U.S. Court of Appeals for the Third Circuit:

- 1. U.S. Airways, Inc., the petitioner on review, was plaintiff-appellee below.
- 2. James McCutchen and Rosen, Louik & Perry, P.C., respondents on review, were defendants-appellants below.

RULE 29.6 DISCLOSURE STATEMENT

Petitioner U.S. Airways, Inc. is a wholly owned subsidiary of U.S. Airways Group, Inc., which owns 10 percent or more of U.S. Airways, Inc. stock. U.S. Airways Group, Inc. is a publicly traded company.

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Supreme Court of the United States

No. 11-1285

U.S. AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN,

Petitioner,

V.

JAMES MCCUTCHEN and ROSEN, LOUIK & PERRY, P.C., Respondents.

> On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF FOR PETITIONER

OPINIONS BELOW

The District Court's order (Pet. App. 18a) is not reported. The Third Circuit's decision (Pet. App. 1a) is reported at 663 F.3d 671.

JURISDICTION

On March 17, 2012, Justice Alito extended the time to file a petition for certiorari to May 3, 2012. The petition was granted on June 25. This Court's jurisdiction rests on 28 U.S.C. § 1254(1).

STATUTE INVOLVED

29 U.S.C. § 1132(a)(3) provides in relevant part:

A civil action may be brought * * * by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan[.]

INTRODUCTION

The Employee Retirement Income Security Act of 1974 ("ERISA") comprehensively regulates employee benefit plans. But that does not mean it negates them. Quite the contrary: As this Court has made clear, ERISA was designed to respect the primacy of written benefit plans. ERISA recognizes that plans are contracts between employers and employees. And the Act provides participants and plans alike with mechanisms to "enforce * * * the terms of the plan." 29 U.S.C. § 1132(a)(1), (a)(3). ERISA's statutory scheme, in short, "is built around reliance on the face of written plan documents." Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 83 (1995).

The court below lost sight of that core principle. Respondent McCutchen was a participant in U.S. Airways' benefit plan. Under that plan, the parties agreed to a simple quid pro quo. U.S. Airways agreed to pay McCutchen's medical expenses in the event that he was ever injured by a third party. McCutchen in turn agreed that he would reimburse the plan in full "out of any monies recovered" from third parties and that he would not "negotiate any agreements" that would divert the plan's reimbursement monies to others.

McCutchen later suffered injuries in an accident and incurred medical bills totaling \$66,866. U.S. Airways lived up to its end of the bargain: It paid for McCutchen's medical care. But McCutchen did not live up to his. When he recovered \$110,000 in third-party settlements, he refused to reimburse the plan.

And when U.S. Airways filed suit, McCutchen argued that he should not have to give back a penny. Though the plan agreement provided for full reimbursement "out of any monies recovered," McCutchen argued that the plan should get nothing unless he recovered 100 percent of the damages he claimed he had suffered. And though the agreement provided that the reimbursement monies could not be diverted to others, McCutchen argued that the money he recovered should go to pay his lawyers' later-agreedto contingency fee. McCutchen argued, in short, that the court should override the plan's text. He relied on ERISA Section 502(a)(3), which authorizes plan fiduciaries to seek "appropriate equitable relief" to "enforce * * * the terms of the plan." 29 U.S.C. § 1132(a)(3). The word "appropriate," he argued, frees courts from the strictures of the written plan agreement and authorizes them to draw widely from equitable principles to fashion a remedy left to be decided by whatever court is hearing the case.

Five circuits had previously rejected that position, holding that refusal to enforce a plan's reimbursement provision would "frustrate, rather than effectuate, ERISA's repeatedly emphasized purpose to protect contractually defined benefits." Zurich Am. Ins. Co. v. O'Hara, 604 F.3d 1232, 1237 (11th Cir. 2010) (citation omitted); see infra at 8-9. But here, the Third Circuit broke with them all and agreed with Respondents. It held that a court faced with an unambiguous reimbursement provision may ignore that provision's terms and fashion relief as it sees fit, engaging in "any additional fact-finding it finds necessary" to arrive at a remedy of its own choosing. Pet. App. 17a.

The Third Circuit's decision conflicts with ERISA and this Court's precedents. Section 502(a)(3) does not empower courts to use free-floating equitable principles to rewrite benefit plans. That is so for three primary reasons. First, Section 502(a)(3) authorizes appropriate equitable relief to "enforce * * * the terms of the plan." 29 U.S.C. § 1132(a)(3) (emphasis added). Respondents' approach does not "enforce the terms of the plan"; it obliterates them. Second, the type of "equitable relief" U.S. Airways seeks here—an equitable lien by agree ent—does not authorize a court to do equity in the abstract, adjusting burdens and benefits long after the fact. An equitable lien by agreement enforces the parties' actual agreement by "regard[ing] * * * as done which was agreed to be done." Runstetler v. Atkinson, 11 D.C. 382, 384 (1883). It "cannot be invoked to create a right contrary to the agreement of the parties." Good v. Jarrard, 76 S.E. 698, 702 (S.C. 1912). Third, Respondents' approach runs headlong into the goals of ERISA. ERISA seeks to minimize litigation burdens; Respondents would multiply them. ERISA seeks to encourage employers to offer benefits; Respondents would discourage them by threatening plan solvency. And ERISA seeks to make liabilities predictable: Respondents would make them utterly unpredictable, subject to the vagaries of litigation and the whim of a single judge.

The decision below accordingly should be reversed.

STATEMENT

A. ERISA and Section 502(a)(3)

1. Enacted in 1974, ERISA places the regulation of private-sector employee benefit plans "primarily under federal jurisdiction for about 177 million people." Congressional Res. Serv., ERISA Regula-

tion of Health Plans: Fact Sheet 1 (Oct. 3, 2007). Congress enacted ERISA to ensure the "fair and prompt enforcement of rights" created under employee benefit plans. Aetna Health Inc. v. Davila, 542 U.S. 200, 215 (2004). To that end, the statute assigns plans specific fiduciary responsibilities; sets minimum standards for plan funding and plan termination insurance; and creates "carefully integrated civil enforcement provisions" available to plan participants, plans themselves, and the Secretary of Labor. Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 146 (1985); see 29 U.S.C. § 1001(b); id. § 1132(a).

Equally important, however, is what ERISA does Both before and after ERISA, employers have chosen whether to offer plans at all and, if so, on what terms, and they set forth the plan terms in written documents that constitute "contracts." CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1879 (2011). ERISA did not override those practices. With very limited exceptions, it does not dictate to employers what benefits or terms to offer: "employers have large leeway to design disability and other welfare plans as they see fit." Black & Decker Disability Plan v. Nord, 538 U.S. 822, 833 (2003). Andimportantly for this case—ERISA is designed to recognize the primacy of, and work in harmony with, written benefit plans. One of the statute's "core functional requirements" is that "'[e]very employee benefit plan shall be established and maintained pursuant to a written instrument." Curtiss-Wright, 514 U.S. at 83 (quoting 29 U.S.C. § 1102(a)(1)) (emphasis in Curtiss-Wright). That is why ERISA's

¹ Available at http://congressionalresearch.com/RS20315/document.php?study=ERISA+Regulation+of+Health+Plans+Fact+Sheet.

enforcement provision, Section 502, authorizes a plan participant to file a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1) (emphases added). Section 502 likewise authorizes plan participants and plans themselves to file civil actions "to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan," and to "obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." Id. § 1132(a)(3) (emphases added).

ERISA, in short, sets up a "straightforward rule" of "hewing to" the contractual "plan documents." Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan, 555 U.S. 285, 300 (2009). That effectuates its "repeatedly emphasized purpose to protect contractually defined benefits." Russell, 473 U.S. at 148.

Congress designed ERISA this way to encourage employers to provide benefits to workers. "Congress enacted ERISA to ensure that employees would receive the benefits they had earned, but Congress did not require employers to establish benefit plans in the first place. We have therefore recognized that ERISA represents a 'careful balancing between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans.' "Conkright v. Frommert, 130 S. Ct. 1640, 1648-49 (2010) (quoting Aetna Health, 542 U.S. at 215). Specifically, "Congress sought 'to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering plans in the first place.' " Id.

(quoting Varity Corp. v. Howe, 516 U.S. 489, 497 (1996)). It did so by "assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 379 (2002). And one of the ways the statute ensures predictable liabilities is by establishing the primacy of the written plan. As this Court has emphasized, ERISA's scheme "is built around reliance on the face of written plan documents." Kennedy, 555 U.S. at 301 (quoting Curtiss-Wright, 514 U.S. at 83).

2. This case concerns Section 502, ERISA's enforcement provision. Section 502(a)(3) authorizes civil actions by plans—which it refers to as "fiduciar[ies]"—as well as by plan participants. It provides that "[a] civil action may be brought * * * by a participant, beneficiary, or fiduciary" to "enjoin any act or practice which violates any provision of this subchapter or the terms of the plan" or to "obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan[.]" Id. § 1132(a)(3).

This Court repeatedly has discussed the remedies available under the "other appropriate equitable relief" language of Section 502(a)(3). In Mertens v. Hewitt Associates, 508 U.S. 248 (1993), the Court construed Section 502(a)(3) to authorize only "those categories of relief that were typically available in equity." Id. at 255-256 (emphasis deleted). And in two later cases—both involving reimbursement actions similar to the one here—the Court made clear that while the relief sought must be "equitable," that statutory descriptor does not prevent plans from enforcing their terms and collecting reim-

bursement. In Great-West Life & Annuity Insurance Co. v. Knudson, 534 U.S. 204, 213 (2002), the Court held that plans may seek restitution for a participant's failure to reimburse so long as the claim is equitable, not legal. And in Sereboff v. Mid Atlantic Medical Services, Inc., the Court explained that reimbursement provisions create an "equitable lien by agreement" that the plan may enforce under Section 502(a)(3). 547 U.S. 356, 364-365 (2006).

The participants in Sereboff had argued that even if the relief the plan sought was "equitable," it was not "appropriate" under Section 502(a)(3). Id. at 368 n.2. That was so, they argued, because the word "appropriate" authorizes courts to consider equitable defenses such as the "make-whole doctrine"—which requires that an insured party be fully compensated for all injuries before a subrogee can obtain any reimbursement, see 16 L. Russ & T. Segalla, Couch on Insurance § 223:134 (3d ed. 2011)—and use those defenses to override the plan's provisions. Id. This Court deemed the argument waived. Id. The Court ordered the plan participants to reimburse their plan some \$74,000—the amount the plan had paid out to cover the participants' medical expenses. Id. at 360.

3. Courts of appeals have confronted the question reserved in Sereboff many times. Until the decision below,² all had answered it in the negative, holding that unambiguous reimbursement provisions should be enforced as written. In Administrative Committee of Wal-Mart Stores, Inc. v. Shank, 500 F.3d 834 (8th Cir. 2007), for example, the plan included a reim-

² Another court, the Ninth Circuit, joined the Third Circuit after the decision below. See CGI Techs. & Solutions v. Rose, 683 F.3d 1113 (9th Cir. 2012), pet. for cert. filed, Aug. 24, 2012 (No. 12-240). CGI is discussed infra at 45.

bursement provision. Id. at 835. Despite the provision's clear terms, the participants argued that full reimbursement was not "appropriate" under Section 502(a)(3), and they asked the court to apply either the "make whole" doctrine or a pro rata share requirement to override it. Id. at 837.

The Eighth Circuit refused to use Section 502(a)(3) "to alter the express terms of a written plan." Id. "Nothing in the statute," it wrote, "suggests Congress intended that section 502(a)(3)'s imitation of the [plan's] recovery to 'appropriate equitable relief would upset [the parties'] contractually defined expectations." Id. at 839. Other circuits have reached the same conclusion, holding that Section 502(a)(3) does not authorize courts to rewrite reimbursement provisions. See O'Hara, 604 F.3d at 1237; Moore v. CapitalCare, Inc., 461 F.3d 1, 9 (D.C. Cir. 2006); Bombardier Aerospace Empl. Welfare Benefits Plan v. Ferrer, Poirot, & Wansbrough, 354 F.3d 348, 357 (5th Cir. 2003); Admin. Comm. of Wal-Mart Stores, Inc. v. Varco, 338 F.3d 680 (7th Cir. 2003).

B. The Decision Below

1. Respondent McCutchen was seriously injured in a 2007 car accident. Pet. App. 3a. McCutchen was covered by a health benefit plan (the "Plan") administered and self-financed by his employer, Petitioner U.S. Airways. The Plan "paid medical expenses in the amount of \$66,866 on his behalf." Id.

McCutchen then sought to recover from third parties for his injuries. He retained counsel and promised his lawyers a 40 percent contingency. *Id.* He and his counsel eventually settled for \$10,000 with the driver who had injured him, and "he and his wife received another \$100,000 in underinsured motorist coverage for a total third-party recovery of \$110,000."

- Id. That recovery, after taking 40 percent for attorney's fees off the top, would amount to \$66,000—\$866 less than U.S. Airways' claimed lien.³
- 2. The Plan contains a reimbursement provision similar to the ones in *Sereboff* and *Knudson*. The provision is summarized in the Plan's Summary Plan Description, in a paragraph entitled "Subrogation and Right of Reimbursement." It provides:

The purpose of the Plan is to provide coverage for qualified expenses that are not covered by a third party. If the Plan pays benefits for any claim you incur as the result of negligence * * * or other actions of a third party, the Plan will be subrogated to all your rights of recovery. You will be required to reimburse the Plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, your own insurance company[.] * * * In addition you * * * may not negotiate any agreements with a third party that would undermine the subrogation rights of the Plan. [J.A. 20 (emphases added).]

Invoking the provision, U.S. Airways sent McCutchen's counsel a letter in June 2007—long before he obtained the settlements discussed above—placing him on notice of a lien against any recovery. Pet. App. 19a-20a. "McCutchen denied the Plan's

³ The record actually does not establish that McCutchen paid a 40 percent contingency on the full \$110,000 settlement, or that his recovery was thereby reduced to \$66,000. It establishes, instead, merely that his attorneys took a 40 percent contingency out of one portion of the settlement—the portion it held in trust, as described below. J.A. 59. Nevertheless, the Third Circuit stated that after fees and expenses, McCutchen's "net recovery was' less than \$66,000." Pet. App. 3a. It presumably reached that conclusion by assuming the attorneys took a 40 percent contingency out of the full settlement amount.

right to reimbursement out of any settlement proceeds." Id. at 19a. He and his counsel proceeded to settle his claims in 2008 without telling U.S. Airways about the larger of the settlements. J.A. 41, 58.

U.S. Airways eventually found out about the settlements. Applying the reimbursement provision by its terms, U.S. Airways asked McCutchen to reimburse the Plan "for the entire \$66,866 that it had paid for [his] medical bills." Pet. App. 3a. McCutchen refused. His attorneys, meanwhile, placed \$41,500 of the \$110,000 recovery in a trust account "for any lien against McCutchen found to be valid." Pet. App. 20a. That \$41,500 reflected the reimbursement amount U.S. Airways sought, reduced by 40 percent for attorney's fees; McCutchen's attorneys "reason[ed] that any lien found to be valid would have to be reduced by a proportional amount of legal costs." Pet. App. 4a.4 The attorneys disbursed the remainder of the recovery to McCutchen.

3. U.S. Airways, acting in its capacity as plan administrator, filed suit, seeking "appropriate equitable relief" under Section 502(a)(3) "in the form of a constructive trust or an equitable lien on the \$41,500 held in trust and the remaining \$25,366 personally from McCutchen." Pet. App. 4a. U.S. Airways argued that the Plan's terms entitled it to full reimbursement. McCutchen, in response, argued that any reimbursement should be reduced or eliminated under doctrines grounded in equitable subrogation—such as the make-whole, common-fund, and pro rata-

^{4 \$41,500} actually reflects a bit less than a 40 percent reduction from \$66,866. The discrepancy apparently arises from the fact that McCutchen's counsel believed the requested reimbursement was \$68,866, rather than \$66,866. J.A. 58-59.

share doctrines⁵—and that U.S. Airways would be "unjustly enriched" if permitted to recover without allowance for attorney's fees. Pet. App. 5a, 28a-32a.

Recognizing that the reimbursement provision's "any monies recovered" language plainly entitled the Plan to full reimbursement, the District Court rejected McCutchen's arguments and granted summary judgment to U.S. Airways. Pet. App. 26a-34a. The court found that "[t]he Plan document clearly requires reimbursement by McCutchen of monies recovered including the * * * benefits paid by his insurance company." Id. at 28a. In so holding, the court rejected McCutchen's attempt to import makewhole, common-fund, or pro rata principles into the analysis. "The US Airways Plan." it wrote, "is unambiguous and requires reimbursement of any payments made by the Plan to the participant[.]" Id. at 32a. U.S. Airways thus was "entitled to full reimbursement of benefits paid under the Plan without reduction" for fees or other offsets. Id.

4. On appeal, McCutchen did not dispute the District Court's finding that the Plan unambiguously required full reimbursement. Nor did he dispute the District Court's finding that the plan unambiguously forbade an offset for attorney's fees. He also abandoned his "make-whole" argument. Appellants' Opening Br. 16 n.7, 2011 WL 791769 (3d Cir. Feb.

The common-fund doctrine, "rooted in concepts of quasi-contract and restitution," provides that in some circumstances a lawyer "who recovers a common fund for the benefit of persons other than himself or his client is entitled to a reasonable attorney's fee from the fund as a whole." Rodriguez v. Disner, ____ F.3d ___, 2012 WL 3241334, at *4 (9th Cir. Aug. 10, 2012) (citations omitted). Under the pro rata share doctrine, a subrogee "receive[s] only partial reimbursement equal to the share of [the subrogor's] settlement that compensates her for medical expenses." Shank, 500 F.3d at 837.

16, 2011) ("Third Circuit Opening Br."). Instead, he minted a new theory to get around the Plan's reimbursement provision: He argued that the court should "limit U.S. Airways to recovering the proportional share of the recovery that is reasonably allocable to the medical expenses that it paid and Mr. McCutchen recovered, less an appropriate reduction for costs and fees." Id. McCutchen argued, in other words, that the court should (1) quantify the abstract "total harm" he suffered in the accident, (2) create a ratio of his actual recovery divided by his "total harm," (3) reduce the reimbursement by that proportion, and then (4) apply common-fund-type principles and reduce the recovery yet again to assign U.S. Airways responsibility for fees and costs. Applying that "proportionality" test, McCutchen argued that his "total harm" amounted to \$1 million; that he had recovered 11 percent of that amount; and that U.S. Airways could recover only 11 percent of its claimed reimbursement-"at most, \$7,355.24 minus appropriate fees and costs." Id. at 6.

Parting with every other court of appeals to have considered the question to that point, the Third Circuit agreed with McCutchen. As the panel saw it, "it would be strange for Congress to have intended that relief under Section 502(a)(3) be limited to traditional equitable categories," as described in Knudson, "but not limited by other equitable doctrines and defenses that were traditionally applicable to those categories." Pet. App. 10a. The panel concluded that one particular doctrine, unjust enrichment, applies in this case because "the principle of unjust enrichment is broadly applicable to claims for equitable relief." Id. at 11a. And the panel made clear its view that the unjust-enrichment rubric

authorizes a court to replace a plan's reimbursement provision with any remedy the court deems fair. Thus the panel wrote that "'[t]he essence of equity jurisdiction has been the power of the Chancellor to do equity and to mould each decree to the necessities of the particular case." Id. at 17a (quoting Hecht Co. v. Bowles, 321 U.S. 321, 329 (1944)). And it explained that the decision on remand could turn on a potpourri of factors, including "the distribution of the third-party recovery between McCutchen and his attorneys * * *, the nature of their agreement, the work performed, and the allocation of costs and risks between the parties to this suit." Id. The court remanded for a determination of what-if anyreimbursement McCutchen should have to provide to the Plan that had paid all his medical expenses.

The panel acknowledged that its conclusion departed from that of every other court of appeals to have confronted the question. Pet. App. 13a-14a. But the panel found support for its holding in this Court's recent decision in CIGNA Corp. v. Amara, which held that courts have "[t]he power to reform contracts" in ERISA cases "to prevent fraud." 131 S. Ct. at 1879 (emphasis added). The panel acknowledged that there was no hint of fraud in this case. Pet. App. 15a. It nonetheless read CIGNA to stand for the broad proposition that "the importance of the written benefit plan is not inviolable, but is subject based upon equitable doctrines and principles—to modification and, indeed, even equitable reformation under Section 502(a)(3)." Id. As the panel saw it, in equity, "contractual language [i]s not as sacrosanct as it is normally considered to be when applying breach of contract principles at common law." Id.

U.S. Airways sought rehearing. It was denied. *Id.* at 41a. It then sought certiorari, which this Court granted.

SUMMARY OF ARGUMENT

- 1. The decision below is contrary to the text of ERISA. Section 502(a)(3) authorizes "appropriate equitable relief" to "enforce * * * the terms of the plan." 29 U.S.C. § 1132(a)(3). The Third Circuit did not "enforce the terms of the plan"; instead it read into Section 502(a)(3) the authority for district courts to rewrite those terms. That is improper statutory interpretation. Nor can the Third Circuit's approach be reconciled with the purposes this Court has long identified in ERISA. ERISA builds its enforcement scheme around the terms of written plan documents, but the decision below subjugates those written agreements to the case-by-case perceptions of individual judges. ERISA is designed to ensure predictable liabilities, but under the approach adopted below those liabilities will vary in every case in ways no one can predict. And ERISA is designed to let employers choose which benefits to offer, but the decision below effectively chooses for them. Third Circuit fled from the statute that was supposed to govern its decision.
- 2. The Third Circuit likewise must be reversed because the uncabined "unjust enrichment" analysis it embraced has no role in the equitable relief at issue here—the equitable lien by agreement. The equitable lien by agreement is designed to enforce the actual agreement a party made. It does not contemplate that a judge will rewrite that agreement—which, no doubt, explains why the approach adopted below lacks support in the cases decided at

common law. Because the Third Circuit did not hew to "the parcel of equitable defenses" accompanying the equitable lien by agreement, Sereboff, 547 U.S. at 368, the principles on which it sought to rely are "beside the point." *Id*.

3. Finally, the rule adopted below would have unfortunate consequences for all involved—employers, employees, and courts. That rule would reduce the reimbursements on which self-funded plans rely to remain solvent and thus would discourage employers from offering benefits in the first place. It would encourage gamesmanship by plan participants. And it would impose new and substantial burdens on federal courts, which would be required to undertake sprawling factual inquiries to decide what is clear from the very face of the plan documents: how much reimbursement the plan is owed. This case is not, and should not be, so complicated. The Court should adhere to the plain meaning of Section 502(a)(3) and reverse the decision below.

ARGUMENT

I. THE DECISION BELOW IS CONTRARY TO ERISA'S TEXT AND PURPOSES.

Respondents argued below, and the Third Circuit agreed, that Section 502(a)(3) authorizes courts to override the clear terms of a benefit plan and replace them with other terms the court thinks fair. That approach cannot be reconciled with the statute. Section 502(a)(3) requires that, where there is an equitable mechanism available to do so, courts should enforce the plan terms as written.

- A. Section 502(a)(3) Authorizes Equitable Relief To Enforce Plans, Not To Rewrite Them.
- 1. Respondents' approach fails, first and foremost, because it cannot be reconciled with the text of Section 502(a)(3). Section 502(a)(3) plainly contemplates "appropriate equitable relief" to "enforce * * * the terms of the plan." 29 U.S.C. § 1132(a)(3) (emphasis added). The provision does not empower district courts to do equity in the air, picking and choosing among common-law remedies to reach a result they think fair on the facts.

This Court recognized the point in Mertens: It wrote that Section 502(a)(3) "does not, after all, authorize 'appropriate equitable relief at large, but only 'appropriate equitable relief for the purpose of 'redress[ing any] violations or * * * enforc[ing] any provisions' of ERISA or an ERISA plan." 508 U.S. at 253 (emphasis in original); accord Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc., 530 U.S. 238, 246 (2000) (quoting this description of Section 502(a)(3)); Peacock v. Thomas, 516 U.S. 349, 353 (1996) (same). As the government similarly told this Court in Sereboff: "Section 502(a)(3) itself makes clear" that "the terms of the ERISA plan * * * are to govern in an action for appropriate equitable relief such as this." Br. of United States as Amicus Curiae, Sereboff v. Mid Atl. Med. Servs., Inc., No. 05-260, 2006 WL 460876, at *28 n.13 (Feb. 23, 2006) ("U.S. Sereboff Br.").

Indeed, other language in Section 502 underscores this point and demonstrates that, when Congress wished to grant courts broad discretion to fashion relief in ERISA, it knew exactly how to do so. Section 502(c)(3) provides that when an employer fails to meet certain notice requirements, "a court may in its discretion order such other relief as it deems proper." 29 U.S.C. § 1132(c)(3). That subsection clearly grants courts more latitude in fashioning remedies than does Section 502(a)(3). And "'when the legislature uses certain language in one part of the statute and different language in another,' " courts must assume that "'different meanings were intended.' " Sosa v. Alvarez-Machain, 542 U.S. 692, 712 n.9 (2004) (quoting 2A N. Singer, Statutes & Statutory Construction § 46:06, at 194 (6th rev. ed. 2000)).

A court presented with a Section 502(a)(3) claim thus should do just what the statute says: It should determine whether the type of equitable relief the plaintiff seeks is "appropriate" to "enforce * * * the terms of the plan," 29 U.S.C. § 1132(a)(3), and, if the answer is yes, the court should enforce those terms. Applying that plain-language approach here, this Court should enforce the Plan's reimbursement provision as written. After all, Sereboff already established that the equitable relief U.S. Airways invoked-the equitable lien by agreement-is a proper type of relief to enforce the terms of a plan's reimbursement provision. See 547 U.S. at 368. The courts below both found, and Respondents do not dispute, that the Plan's reimbursement provision unambiguously requires McCutchen to fully reimburse the Plan.6 And Respondents likewise do not

⁶ The District Court concluded that the reimbursement provision was "clear and unambiguous," Pet. App. 30a, and Respondents did not contest that finding on appeal. The Third Circuit thus recognized that under the provision "a beneficiary is required to reimburse the Plan for any amounts it has paid out of any monies the beneficiary recovers from a third party." Pet. App. 5a. Moreover, Respondents in their certiorari-stage papers again conceded the point, writing that under the reimbursement provision a participant must "reimburse the

dispute that U.S. Airways' action fulfills the criteria for perfecting an equitable lien by agreement. See infra at 31. The Court accordingly should "enforce * * * the terms of the plan." 29 U.S.C. § 1132(a)(3).

2. The Third Circuit interpreted Section 502(a)(3) to import into every ERISA plan an implicit limitation on the plan's rights: Full reimbursement is permitted only where, in a particular court's view, it is justified under the facts of a particular case. Pet. App. 16a-17a. But that interpretation does substantial violence to the statute's command. Under the Third Circuit's approach, the court does not "enforce * * * the terms of the plan," 29 U.S.C. § 1132(a)(3); it rewrites them. That is directly at odds with the Court's "duty 'to give effect, if possible, to every clause and word of a statute." Duncan v. Walker, 533 U.S. 167, 174 (2001) (citation omitted). As this Court wrote in Mertens: "The authority of courts to develop a 'federal common law' under ERISA * * * is not the authority to revise the text of the statute." 508 U.S. at 259 (citation omitted).

Neither Respondents' briefing below nor the Third Circuit's opinion made any attempt to address this fatal difficulty with Respondents' interpretation. Instead, both simply ignored the problem by proceeding as if the "enforce the terms of the plan" language in Section 502(a)(3) did not exist. Respondents' opening brief to the Third Circuit quoted the phrase "appropriate equitable relief" nine times—but except for an obligatory footnote reproducing the full statutory text (see Third Circuit Opening Br. 4 n.3), Respondents never once quoted the second half of the

Plan for any amounts it has paid out of any monies the beneficiary recovers from a third-party, without any contribution to attorneys' fees." Brief in Opposition 5.

sentence, which ties that relief to "enforc[ing]" the "terms of the plan." The Third Circuit followed suit: Its opinion quoted the phrase "appropriate equitable relief" fourteen times, see Pet. App. 2a, 4a, 7a, 9a, 10a, 12a, 14a, 16a, 17a, and yet it never discussed the rest of the sentence. But courts "do not *** construe statutory phrases in isolation; [they] read statutes as a whole. Thus, the words [in question] must be read in light of the immediately following phrase." United States v. Morton, 467 U.S. 822, 828 (1984). The court below ignored that guidance, at Respondents' behest, and was led astray.

- 3. Respondents offered a pair of arguments below to justify their position: first, that the statute's use of "appropriate" in the phrase "appropriate equitable relief" must be read to give courts freewheeling discretion to embrace equitable offsets; and second, that this Court's decision in CIGNA authorized courts to rewrite benefit plans even absent fraud. The Third Circuit accepted both arguments. Pet. App. 9a, 15a-16a. That was error twice over.
- a. Respondents argued below (Third Circuit Opening Br. 21) that "if it is to have any meaning at all," the word "appropriate" must authorize courts to import any and all equitable principles required to reach what the court considers a fair result—principles that, at various stages of Respondents' briefing, have included the make-whole doctrine, the common-fund doctrine, the pro rata share doctrine, and Respondents' later-arriving "proportionality" theory. They argued, in other words, that "appropriate" either authorizes courts to rewrite benefit plans or it is a nullity. Id.; see also Brief in Opposition 26. But that is demonstrably incorrect. "Appropriate" in Section 502(a)(3) comfortably bears a much more

sensible meaning: It requires that the type of "equitable relief" the plaintiff seeks be suitable under the circumstances to enforce the plan.

That understanding of "appropriate" is reflected in this Court's precedent. In Harris Trust, the Court applied Section 502(a)(3) by asking whether, at equity, the common law "countenance[d] the sort of relief sought by petitioners." 530 U.S. at 250 (emphasis added). Answering in the affirmative, the Court concluded that petitioners' action "satisfies the 'appropriate[ness]' criterion in § 502(a)(3)." Id. at 253 (alteration in original). In CIGNA, the Court explained that it has "interpreted the term 'appropriate equitable relief in § 502(a)(3) as referring to 'those categories of relief' that, traditionally speaking (i.e., prior to the merger of law and equity) were typically available in equity." 131 S. Ct. at 1878 (quoting Sereboff, 547 U.S. at 361). And in Knudson, the Court explained that to be "appropriate equitable relief" the relief must conform with "the conditions that equity attached to its provision." 534 U.S. at 216. The Court, in sum, has long understood "appropriate" equitable relief under Section 502(a)(3) to be equitable relief of a type suitable under the circumstances to "enforce [the statute] or the terms of the plan." 29 U.S.C. § 1132(a)(3). The Court has never understood the word "appropriate" to override the second half of the statutory phrase-"enforce the terms of the plan." Nor has it understood "appropriate" to authorize courts to choose from a grab-bag of equitable principles even if—as we discuss below those principles have no relationship to the particular type of relief the plaintiff seeks.

ERISA's text further supports this understanding of "appropriate." Section 502(a)(2)—the provision

immediately adjacent to the one at issue here authorizes suit "by the Secretary, or by a participant, beneficiary, or fiduciary for appropriate relief under section 1109 of this title." 29 U.S.C. § 1132(a)(2) (emphasis added). Section 1109, in turn, authorizes suits against fiduciaries and provides for a variety of remedies, including money damages. The only plausible reading of "appropriate" in 502(a)(2) is that it means remedies suitable under 29 U.S.C. § 1109. The Court should understand the word to mean the same thing in Section 502(a)(3). See Morrison-Knudsen Constr. Co. v. Director, Office of Workers' Compensation Programs, 461 U.S. 624, 633 (1983) ("[A] word is presumed to have the same meaning in all subsections of the same statute").

In this case, then, the word "appropriate" requires that the equitable relief that is sought be suitable to enforce the terms of the Plan. Here it is. The Court held in Sereboff that the equitable lien by agreement is suitable to enforce reimbursement provisions. See 547 U.S. at 368. And as we discuss infra at 31, the reimbursement provision here meets all the criteria for an enforceable equitable lien by agreement. That should be the end of the matter. The word "appropriate" in Section 502(a)(3) can bear no more weight than that.

b. Respondents and the Third Circuit also relied heavily on this Court's decision in CIGNA for their understanding of Section 502(a)(3). See Pet. App. 7a, 10a, 11a, 15a-16a. That reliance is misplaced. CIGNA involved a situation in which a plan "intentionally misled its employees" about the benefits the plan provided. 131 S. Ct. at 1874. This Court explained that in such a circumstance, courts enjoy the power to reform the plan in order "to remedy the

false or misleading information [the plan] provided."

Id. at 1879. That was so because "[t]he power to reform contracts * * * is a traditional power of an equity court * * * and was used to prevent fraud."

Id. As the Court explained, "equity often considered reformation a 'preparatory step' that 'establishes the real contract,' "id. (quoting 4 S. Symons, Pomeroy's Equity Jurisprudence § 1375, at 999 (5th ed. 1941) ("Pomeroy")), and accordingly "equity would reform the contract, and enforce it, as reformed, if * * * mistake or fraud were shown.' "Id. (citation omitted).

The Third Circuit correctly acknowledged that there has been no allegation here that Petitioner was "fraudulent or dishonest" in any way. Pet. App. 15a. The panel nonetheless read CIGNA to stand for a proposition far broader than that case permits: that in equity, "contractual language [i]s not as sacrosanct as it is normally considered to be when applying breach of contract principles at common law." Id. From that errant premise, the panel concluded that "the importance of the written benefit plan is not inviolable, but is subject—based upon equitable doctrines and principles—to modification and, indeed, even equitable reformation under Section 502(a)(3)." Id.

That conclusion does not follow from CIGNA. CIGNA suggested only that a court could reform an ERISA plan to prevent fraud or mistake. That reformation power is entirely consistent with U.S. Airways' view of Section 502(a)(3) because where there is fraud or mutual mistake there are no mutually agreed "terms" to "enforce." 29 U.S.C. § 1132(a)(3). See 4 Pomeroy § 1375, at 999 (reformation "establishes the real contract"). But CIGNA

went no further than fraud or mistake. And correctly so, for "it is well settled * * * 'that a court of equity, in the absence of fraud, accident, or mistake, cannot change the terms of a contract." Manufacturers' Fin. Co. v. McKey, 294 U.S. 442, 449 (1935) (quoting Hedges v. Dixon County, 150 U.S. 182, 189 (1893)) (emphasis added); accord Restatement (Second) of Contracts § 153 (1979). It is equally well settled, as we explain infra at 31-37, that a court of equity enforcing an equitable lien by agreement enforces the parties' agreement as written absent carefully circumscribed exceptions—one of which is fraud. CIGNA is consistent with that nearly 200-year-old jurisprudence; the Third Circuit's sweeping expansion of CIGNA is not.

In short, CIGNA does not give federal courts the power to rewrite the general terms of an agreement. Rather, the Court's analysis of the fraud principle explicitly underscored the controlling nature of the "real contract" to which the parties agreed. 131 S. Ct. at 1880 (quoting 4 Pomeroy § 1375, at 999). And nothing in CIGNA casts doubt on the command of Section 502(a)(3): Courts may do equity only to "enforce *** the terms of the plan." 29 U.S.C. § 1132(a)(3). The Third Circuit's use of fraud principles to justify reformation of agreements where there is no fraud should be rejected.

B. Petitioner's Approach To Section 502(a)(3) Honors ERISA's Purpose And Design.

Petitioner's approach to Section 502(a)(3) is especially compelling—and Respondents' approach all the more unacceptable—because the former honors ERISA's purpose and design, while the latter does not.

1. ERISA "is built around reliance on the face of written plan documents." Curtiss-Wright, 514 U.S. at 83. That statutory purpose is served by enforcing unambiguous plan terms as written. It is not served by eliminating or rewriting lawful plan provisions. Much less is it served by eliminating or rewriting lawful plan provisions in the guise of applying a congressional directive to "enforce * * * the terms of the plan." 29 U.S.C. § 1132(a)(3). To accept Respondents' approach would "frustrate, rather than effectuate, ERISA's 'repeatedly emphasized purpose to protect contractually defined benefits.' "O'Hara, 604 F.3d at 1237 (quoting Russell, 473 U.S. at 148).

The point carries special force in reimbursement cases, like this one. As courts have observed, reimbursement provisions amount to an exchange for value. See Shank, 500 F.3d at 839. The plan commits to pay a participant's medical bills. The participant makes premium payments, and promises to reimburse the plan for its payments on his behalf if he receives any judgment or settlement from third parties. Given that guid pro quo, it does not serve ERISA's purposes—and indeed it is neither "appropriate" nor "equitable"—to permit the participant to rewrite the agreement after the fact so that he keeps the benefit to which he agreed but shirks the burdens. As the Eighth Circuit put it: "Having received medical benefits in accordance with the [written planl, we will not permit a participant to deny the corresponding responsibilities and obligations that are clearly imposed on the participant in the same document—what is good for the goose is good for the gander." Administrative Comm. of Wal-Mart Stores, Inc. v. Gamboa, 479 F.3d 538, 545 (8th Cir. 2007); accord Ryan v. Federal Express, 78 F.3d 123, 127-128

(3d Cir.1996) ("[I]t would be inequitable to permit the Ryans to partake of the benefits of the Plan and then * * * invoke common law principles to establish a legal justification for their refusal to satisfy their end of the bargain"). Quite so. If ERISA is built around reliance on the written plan, that reliance should redound to both parties' benefits.

2. The Third Circuit's rule also runs counter to ERISA's design to induce employers to offer benefits by assuring "a predictable set of liabilities," "uniform standards of primary conduct," and "a uniform regime" of remedies in the event of a violation. Rush Prudential, 536 U.S. at 379.

As this Court has recognized, "[u]niformity is impossible * * * if plans are subject to different legal obligations in different States." Egelhoff v. Egelhoff, 532 U.S. 141, 148 (2001). But that is precisely the result under the Third Circuit's rule: The hundreds of federal judges who populate the nearly 100 federal judicial districts all would enjoy the discretion to enforce reimbursement provisions as they see fit. Plan providers thus would have to "calculate benefit levels * * * based on liability conditions" that vary state-by-state, judge-by-judge. FMCv. Holliday, 498 U.S. 52, 60 (1990). That would be a burdensome task, to put it mildly. As "a group of prominent actuaries" explained to this Court in Conkright: "[I]t is impossible even to determine whether an ERISA plan is solvent * * * if the plan is interpreted to mean different things in different places." 130 S. Ct. at 1649. "Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement." Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990).

As for predictability, it goes out the window under the Third Circuit's rule. Any judge can reach any result with respect to reimbursement obligations, based on any and all fairness considerations that can be shoehorned within the rubric of "unjust enrichment." That, too, runs counter to ERISA's goals. As one court observed, criticizing the Third Circuit's decision in this case: "An untamed sense of 'equity.' detached from ERISA's purpose and context, is antithetical to ERISA because every man's notion of equity is uncertain and variable." Schwade v. Total Plastics, Inc., 837 F. Supp. 2d 1255, 1276 (M.D. Fla. 2011). "Although perhaps momentarily gratifying to the sensibilities of a judge, foisting an involuntary and unpredictable obligation on an ERISA plan endangers both the statutory ERISA regime and the salutary benefits broadly available as a result of the regime." Id. at 1279. It is the opposite of what Congress intended.

3. The Third Circuit's rule also undercuts ERISA by favoring one particular individual at the expense of all other plan participants. ERISA is "primarily concerned" with "remedies that *** protect the entire plan, rather than with the rights of an individual beneficiary," Russell, 473 U.S. at 142, and plans must "preserve assets to satisfy future, as well as present, claims." Varity, 516 U.S. at 514. But the rule adopted below runs in exactly the opposite Where a beneficiary is "relieved of his direction. obligation to reimburse [a plan] for the medical benefits it paid on his behalf, the cost of those benefits [will] be defrayed by other plan members and beneficiaries in the form of higher premium payments." O'Hara, 604 F.3d at 1238; accord Shank, 500 F.3d at 838; Harris v. Harvard Pilgrim Health

Care, Inc., 208 F.3d 274, 280-281 (1st Cir. 2000); Cutting v. Jerome Foods, Inc., 993 F.2d 1293, 1297 (7th Cir. 1993) (Posner, J.) ("Without subrogation," the insured "pays more for the insurance[.]"); H. Dagan & J.J. White, Governments, Citizens, & Injurious Industries, 75 N.Y.U. L. Rev. 354, 390 n.149 (2000); M.C. Campbell, Non-Consensual Suretyship, 45 Yale L.J. 69, 100 (1935). Undercutting reimbursement rights thus "harm[s] other plan members and beneficiaries by reducing the funds available to pay th[eir] claims." O'Hara, 504 F.3d at 1238.

4. Finally, the rule adopted below cannot be reconciled with Congress' decision to give employers broad control over plan design. Congress in ERISA deliberately chose not to "mandate what kind of benefits employers must provide if they choose to have * * * a plan," Lockheed Corp. v. Spink, 517 U.S. 882, 887 (1996); employers thus "have large leeway to design disability and other welfare plans as they see fit." Nord, 538 U.S. at 833. Exercising that leeway, plans with reimbursement provisions make a choice—often driven by cost concerns—to provide conditional Participants have the right to receive benefits: payments from the plan and to keep those payments unless and until they collect from a third party. That is an affirmative choice about the quantum of benefits to offer. And it is the choice U.S. Airways made in this case: Its plan documents made clear that "the purpose of the Plan is to provide coverage for qualified expenses that are not covered by a third party." J.A. 20 (emphasis added).

Congress chose to embrace plans' freedom to make that choice. The rule adopted below eliminates that freedom, effectively recalibrating plans' benefit levels against their will. That, again, is not what Congress had in mind.

For all of these reasons, the approach advanced by Respondents and adopted below cannot be squared with ERISA's text or purposes.

II. THE APPROACH ADOPTED BELOW CANNOT BE SQUARED WITH THE EQUITABLE LIEN BY AGREEMENT.

The Third Circuit's approach must be rejected for a second, independent reason: Even if Section 502(a)(3) did not expressly direct courts to "enforce * * * the terms of the plan," the particular equitable remedy at issue here directs just that.

The treatises and cases dating to the days of the law-equity divide establish that the equitable lien by agreement exists for one purpose: to "enforce" the terms of an "agreement of the parties." 1 Dan B. Dobbs, Law of Remedies § 4.3(3), at 601 (2d ed. 1993) (Dobbs); 4 Pomeroy § 1234, at 694-695. Indeed, the equitable lien by agreement "cannot be invoked to create a right contrary to the agreement of the parties." Good, 76 S.E. at 702. It accordingly does not permit the freewheeling equitable adjustments the Third Circuit thought acceptable.

The Third Circuit's contrary conclusion was based on a mistake of law: It conflated the equitable lien by agreement with the equitable lien imposed to avoid unjust enrichment, and then grafted principles that have been applied to the latter onto the former. But as this Court explained in Sereboff, the two types of liens "[a]re different species of relief," and the principles the Third Circuit found controlling accordingly are "beside the point." 547 U.S. at 364-

365, 368. For this reason, too, the decision below cannot stand.

A. The Relief At Issue Here Is An Equitable Lien By Agreement.

1. In Sereboff, this Court held that where a plan pursues recovery pursuant to a reimbursement provision, the equitable relief being sought is the "equitable lien by agreement." 547 U.S. at 364-365; id. at 368. The Court unanimously described the contours of the equitable lien by agreement by looking to treatises and "case law from the days of the divided bench." Id. at 363. It explained that under an equitable lien by agreement, "'a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets a title to the thing." Id. at 363-364 (quoting Barnes v. Alexander, 232 U.S. 117, 121 (1914)). explained that a reimbursement provision creates an enforceable equitable lien by agreement so long as it "specifically identifie[s] a particular fund, distinct from the [participant's] general assets" and "a particular share of that fund to which [the plan] was entitled." Id. at 364.

Those criteria were met in Sereboff, the Court held, because the reimbursement provision at issue identified a particular fund distinct from general assets—namely, "all recoveries from a third party"—and a particular share to which the plan was entitled—namely, "that portion of the total [tort] recovery which is due [to the plan] for benefits paid." Id. The Court rejected the participant's attempt to characterize the plan's reimbursement provision as invoking other sorts of equitable remedies, such as equitable restitution or equitable subrogation. As the Court explained: "[The plan's] claim is not considered

equitable because it is a subrogation claim. * * * [It] qualifies as an equitable remedy because it is indistinguishable from an action to enforce an equitable lien established by agreement, of the sort epitomized by our decision in *Barnes*." *Id.* at 368.

2. The U.S. Airways Plan's subrogation provision creates an enforceable equitable lien by agreement. The provision, just like the one at issue in Sereboff. requires participants to reimburse the Plan in full when they obtain recoveries from third parties. J.A. It identifies a particular fund distinct from 20. McCutchen's general assets-namely "any monies recovered from a third party." Id. And it identifies a particular share of that fund to which U.S. Airways was entitled-namely, the "amounts paid for claims." Id. Indeed, Respondents never challenged the fact that U.S. Airways' claim meets those elements. The relief U.S. Airways seeks thus "is indistinguishable from an action to enforce an equitable lien established by agreement," Sereboff, 547 U.S. at 368, and U.S. Airways could "follow a portion of the recovery into [McCutchen's] hands as soon as [the settlement fund) was identified." Id. at 364 (quoting Barnes, 232 U.S. at 123) (quotation marks omitted).

B. Equitable Liens By Agreement Enforce Parties' Agreements By Their Terms.

The fact that Petitioner seeks equitable relief by agreement is fatal to Respondents' position. That is so because the raison d'etre of the equitable lien by agreement is to enforce agreements by their terms.

1. The equitable lien by agreement is premised on the maxim that "equity will regard that as done which was agreed to be done." Runstetler, 11 D.C. at 384; accord 4 Pomeroy § 1235, at 696-698; Dobbs § 4.3(3), at 601; 51 Am. Jur. 2d Liens § 40. The equitable lien thus enforces the agreement that the parties actually made, not a different agreement that a judge sitting in equity thinks the parties ought to have made.

That principle has been recognized widely for well over a century, including by this Court. Thus, for example, in Wheeler v. Insurance Co., 101 U.S. 439, 442 (1879), this Court explained in an equitable-lienby-agreement case that "[o]f course the mortgagee's equity will be governed by the scope and object of the agreement." In Parlin & Orendoff Implement Co. v. Moulden, 228 F. 111, 113 (5th Cir. 1916), the Fifth Circuit wrote in an equitable-lien-by-agreement case that the lienors "were entitled to have the proceeds of the insurance policies applied as the bankrupt agreed that they should be applied—to treat that as having been done which had agreed to be done." In Bernard v. Lea, 210 F. 583, 595 (4th Cir. 1913), the Fourth Circuit wrote in an equitable-lien-byagreement case that "[e]quity seeks to effectuate the intention of the parties to contracts and will, to that end, aid their * * * execution." And in Daggett v. Rankin, 31 Cal. 321, 326 (1866), the California Supreme Court explained that "[t]he maxim of equity upon which this doctrine rests is that equity looks upon things agreed to be done as actually performed."

The list goes on.7 And in every case the basic principle of the equitable lien by agreement is described

⁷ See, e.g., Alden v. Garver, 32 Ill. 32, 35 (1863) ("When intendments are made, it is for the purpose of effectuating the real intention of the parties."); Foster Lumber Co. v. Harlan County Bank, 80 P. 49, 50 (Kan. 1905) ("Equity treats that as done which a party, under his agreement, ought to have done"); Standorf v. Shockley, 111 N.W. 622, 623 (N.D. 1907) ("Equity

the same way: "[E]quity will treat as done that which by agreement is to be done." United States Fidelity & Guar. Co. v. Fidelity Trust Co., 153 P. 195, 199 (Okla. 1915). A court recognizing an equitable lien by agreement accordingly does not stop to ask whether it should recalibrate the parties' bargain based on some after-the-fact notion of fairness. The court enforces the lien under the terms of the agreement—just as the parties had intended.

The "standard current works," Knudson, 534 U.S. at 217, concur. As Pomeroy observes, "[t]he theory of equitable liens has its ultimate foundation *** in contracts, express or implied." 4 Pomeroy § 1234, at 695; accord Dobbs § 4.3(3), at 601 (equitable liens by agreement are "created by express or at least implied-in-fact agreement of the parties" and are "recognized and enforced in the courts of equity"). Thus "in a large class of executory contracts *** equity recognizes, in addition to the personal obligation, a peculiar right over the thing concerning which the contract deals, which it calls a 'lien.' "4 Pomeroy § 1234, at 695. And "by means of" the equitable lien by agreement, "the plaintiff is enabled to follow the identical thing, and to enforce the defendant's obliga-

comes to the aid of the parties *** and gives effect to their intention"); Hovey v. Elliot, 73 Sickles 124, 136 (N.Y. 1890) ("In equity [the contract] had effect as a lien *** upon the principle that what is agreed and ought to be done is regarded as done."); Southern Ice & Coal Co. v. Alley, 154 S.W. 536, 539 (Tenn. 1913) (quoting Daggett).

⁸ This maxim is sometimes stated as "[e]quity regards as done that which ought to be done." E.g., Walker v. Brown, 165 U.S. 654, 665 (1897). But notably, "that which ought to be done is what the parties have contracted to do, but have not done. It is not grounded on mere moral obligation[.]" Stone v. First Nat'l Bank of Tillamook, 198 P. 244, 244-245 (Or. 1921) (emphasis added); accord Bair v. Willis, 129 S.E.2d 774, 777 (Ga. 1963).

tion by a remedy which operates directly upon that thing." Id. (emphasis added). Nor does it matter if the property is "not yet in being at the time when the contract is made"; the lien is still "enforced in the same manner and against the same parties as a lien upon specific things existing and owned by the contracting party at the date of the contract." Id. § 1236 at 699-700; accord 51 Am. Jur. 2d Liens § 40.

The upshot: Courts long have understood that the agreement itself defines the rights and remedies available under an equitable lien by agreement. As the South Carolina Supreme Court put it, "[t]he rule that equity considers done that which should be done cannot be invoked to create a right contrary to the agreement of the parties." Good, 76 S.E. at 702.

2. Given that principle, it is unsurprising that as best as we can tell, courts sitting in equity have never done what the Third Circuit did here: interject vague principles of unjust enrichment or public policy to rewrite an equitable lien by agreement. Petitioner's counsel has reviewed several hundred equitable-lien-by-agreement cases from the days of the divided bench, including every such case cited in the Pomeroy treatise. In none did the court embrace such an approach, and in several the court squarely rejected attempts to invoke it.

In several cases, for example, defendants objected to an equitable lien by agreement on the ground that it was in derogation of their right to a homestead (a right based in public policy). The courts disagreed. Homestead owners, they explained, have "perfect liberty and freedom to so contract or not." Adkinson & Bacot Co. v. Varnado, 47 So. 113, 115 (Miss. 1908). Thus, although the "books are full of statements with respect to the law of establishment of homesteads,"

those laws, and the public policy they embody, "have no sort of application" where the defendants agreed to give the plaintiff their property or an interest in it. Id. at 116; accord Parlin, 228 F. at 113-114 (equitable lien by agreement not defeated by homestead rights); Foster Lumber Co. v. Harlan Cnty. Bank, 80 P. 49, 51 (Kan. 1905) (same).9

Indeed, Barnes v. Alexander—the case described at length in Sereboff—stands for the same basic proposition. There, an attorney had promised one-third of his contingency fee to two other attorneys. His widow refused to hand over the money to those attorneys as promised. Among other things, she argued that the lien should at least be reduced because she had not received her husband's full two-thirds share; some of it had been distributed to her husband's law partner. 232 U.S. at 122-123. This Court squarely rejected that argument. It held that "the moment the fund was received the contract attached to it as if made at that moment," and it observed that "[a]s the lien of the appellees attached to the whole two thirds of the [contingency fee], we

One of the homestead cases echoes the circumstances here. In Farmers' Mutual Insurance Ass'n v. Burch, 25 S.E. 211 (S.C. 1896), defendants participated in a mutual insurance association in which members agreed to pay a share of other members' losses. Id. at 213. To secure that obligation, members granted the association a lien over their lands. Id. One member later protested that the lien infringed his homestead rights. Id. The court rejected the argument on technical grounds, but it also observed that the lien in fact furthered public policy by making sure funds were available to protect all members against loss. Id. at 214. The same policy applies here. See supra at 27. Plans must "preserve assets to satisfy future, as well as present, claims," Varity, 516 U.S. at 514, and reimbursement provisions "inure[] to the benefit of all participants * * * by reducing the total cost of the Plan." O'Hara, 604 F.3d at 1237-38.

do not see on what ground she could complain[.]" Id. at 121, 123. The Court, in other words, refused to reduce or rewrite the equitable lien by agreement based on a generalized concept of unjust enrichment or fairness. Rather, it determined that the prior agreement controlled. The same rule applies here.

3. Equity courts did discuss, and in some cases recognize, some other defenses to equitable liens by Those defenses fell into three discrete agreement. categories, none of which are relevant to this case or aid Respondents. First, some courts suggested that an equitable lien by agreement might be unenforceable where the agreement was the product of fraud or mistake or constituted usury. See v. Hoveland, 58 N.W. 947, 949 (Neb. 1894) (fraud); Butts v. Broughton, 72 Ala. 294, 297 (1882) (usury). Second, some courts suggested that an equitable lien by agreement would be unenforceable where the lienholder waived it or let it lapse, a defense akin to laches. See Gill v. Clark, 54 Mo. 415, 417-418 (1873) (waiver); H.G. Fitzhugh v. Smith, 62 Ill. 486, 492 (1872) (laches). Finally, some courts declined to enforce equitable liens by agreement where the current holder of the fund was a bona fide purchaser without notice or where the lien would constitute a fraudulent transfer. See, e.g., Walker v. Brown, 165 U.S. at 654, 664-665 (1897); Hanson v. W.L. Blake & Co., 155 F. 342, 360 (D. Me. 1907).

Notably, none of these defenses authorized courts to rewrite the parties' bargain to deviate from their actual agreement. None involved roving inquiries into unjust enrichment. And none allowed the equitable lien to be modified by letting the defendant make payments to third parties—here, McCutchen's attorneys—out of recovered funds before the plaintiff

could receive reimbursement. On the contrary, an equitable lien by agreement "create[s] a lien * * * as soon as [the fund] [i]s identified," making the defendant merely "a trustee as soon as he gets a title to the thing," Sereboff, 547 U.S. at 364 (quoting Barnes, 232 U.S. at 121-123), and that lien is superior to other obligations the defendant may have incurred. Dobbs § 4.3(3), at 600. The money recovered by a plan participant therefore is the plan's property from the moment it is recovered, and that entitlement defeats others' claims.

Thus even if the "parcel of equitable defenses" applicable to equitable liens by agreement are cognizable under Section 502(a)(3), Sereboff, 547 U.S. at 368, those equitable defenses do not salvage the Third Circuit's opinion. Respondents do not advance any of the arguments that might even conceivably void an equitable lien by agreement in equity law. Instead, they have argued that the courts should draw from generalized notions of equity to impose a "proportionality" principle on Petitioner's recovery and to make Petitioner share, "common fund"-style, in McCutchen's attorney's fees. That approach is simply not grounded in any doctrine that equity courts have applied to equitable liens by agreement. And it is a far cry from the standard this Court has employed in "interpret[ing] the term 'appropriate equitable relief in 502(a)(3) as referring to 'those categories of relief that traditionally speaking (i.e. prior to the merger of law and equity) 'were typically available in equity." CIGNA, 131 S. Ct. at 1878 (quoting Sereboff, 547 U.S. at 361).

C. The Third Circuit Reached A Different Result By Applying The Wrong Equitable Principles.

The Third Circuit came to a different conclusion. It held that "the principle of unjust enrichment is broadly applicable to claims for equitable relief," that that principle accordingly must apply to the equitable relief sought here, and that it authorizes a court to recalibrate the parties' bargain however the court sees fit. Pet. App. 11a, 16a-17a. But "the principle of unjust enrichment" is not applicable here—at least not in the freewheeling form the Third Circuit envisioned. The Third Circuit reached a contrary conclusion because it erroneously equated an equitable lien by agreement with an equitable lien to prevent unjust enrichment.

1. In Sereboff, this Court was careful to distinguish the equitable lien by agreement from two other forms of relief: equitable restitution and equitable subrogation. The Court explained that "an equitable lien sought as a matter of restitution[] and an equitable lien 'by agreement' * * * [a]re different species of relief." 547 U.S. at 364-365. And it recognized that the "equitable lien established by agreement" is distinct from "equitable subrogation," such that "the parcel of equitable defenses * * * accompany[ing] any such action [for equitable subrogation] are beside the point." Id. at 368.

Not only this Court, but the equity treatises, too, draw a sharp line between these forms of relief. Dobbs, for example, makes special mention of the equitable lien by agreement "to distinguish it from the equitable lien imposed by the courts to prevent unjust enrichment"; the latter—also described generally as equitable restitution—is imposed "not as a

matter of contract, but to prevent unjust enrichment." Dobbs § 4.3(3), at 601; compare 51 Am. Jur. 2d Liens §§ 40-44 (equitable liens by agreement) with id. §§ 47-50 (equitable liens imposed to prevent unjust enrichment). Likewise, Dobbs and the other treatises treat equitable liens by agreement and equitable subrogation as two different remedies. See, e.g., Dobbs § 4.3(3)-(4), at 600-608; 1 George E. Palmer, The Law of Restitution § 1.5(a)-(b), at 20-24 (1978); compare 4 Pomeroy §§ 1233-43, at 691-710 (equitable liens by agreement), with id. § 1419, at 1072-75 (equitable subrogation). Like equitable restitution, equitable subrogation is "used to prevent unjust enrichment and to give effective relief to the plaintiff." Dobbs § 4.3(4), at 604.

2. The Third Circuit failed to take heed of these distinctions. As a result, it relied for its sweeping conclusions about unjust enrichment not on treatise sections discussing equitable liens by agreement, but on those discussing the *other* two remedies—equitable restitution and equitable subrogation. Here is the key passage from the Third Circuit's opinion:

These [treatises cited in Knudson] all support McCutchen's position that the principle of unjust enrichment is broadly applicable to claims for equitable relief. See 1 Dan Dobbs, Law of Remedies § 4.3(3), at 602 (2d ed. 1993) (noting that equitable remedies such as constructive trusts and equitable liens are all "invoked for the same reason, to prevent unjust enrichment"); 1 Palmer, Law of Restitution § 1.1, at 4 ("In equity the principal remedy is constructive trust; but equitable lien, subrogation, and accounting are techniques fre-

quently used to prevent unjust enrichment."). [Pet. App. 11a].

The Dobbs and Palmer excerpts quoted in this passage, however, are not about equitable liens by agreement at all. They deal instead with equitable restitution-i.e., equitable liens to remedy unjust enrichment. And as this Court made clear in Sereboff, that is a "different species of relief." 547 U.S. at 364-365. Ignoring this key distinction, the Third Circuit failed to recognize that the equitable lien by agreement is governed by different rules that are based on the agreement itself. It is not imposed after the fact to remedy unjust enrichment; it exists from "the moment the fund was received," Barnes, 232 U.S. at 121, and it "treat[s] that as having been done which had agreed to be done." Parlin, 228 F. at 113. Nothing in the treatises on which the Third Circuit relied is to the contrary.

The Third Circuit's failure to distinguish between different forms of equitable relief is in this respect similar to the analytic mistake of the plan participants in Sereboff. The participants "assume[d] that Knudson endorsed application of all the restitutionary conditions * * * to every action for an equitable lien under § 502(a)(3)," but as the Court explained, that "assumption [wa]s inaccurate" because principles applicable to one form of equitable relief do not necessarily apply to "all the circumstances in which equitable liens were available in equity." 547 U.S. at 365-366. Quite so here as well. The Third Circuit's assumption that the principles governing equitable restitution and subrogation apply here is wrong. The equitable lien by agreement, like Section 502(a)(3) itself, contemplates that courts will enforce agreements by their terms.

Finally, even if the Third Circuit had been correct to import generalized unjust-enrichment principles here, its decision still could not stand for two reasons. First, as discussed supra at 25-26, there is nothing equitable about letting a participant enjoy the benefit of the parties' bargain and then shrink from the responsibilities imposed by that same bargain. Second, equity does not open the door to judicial rewriting of contractual terms on unjustenrichment grounds. On the contrary, "the terms of an enforceable agreement normally displace any claim of unjust enrichment within their reach." Restatement (Third) of Restitution & Unjust Enrichment § 2 cmt. c (emphasis added). That is so because "one who is enriched by what he is entitled to under a contract or otherwise is not unjustly enriched." Dobbs § 2.4(5), at 111, § 4.1(2), at 558; accord Craig v. Bemis Co., 517 F.2d 677, 684 (5th Cir. 1975) ("[E]nrichment [is] not 'unjust,' where it is allowed by the express terms of the Plan."). So it is here. A "plaintiff's contract should not be rewritten to avoid hardship to the defendant." Dobbs § 2.4(5), at 111.

Ultimately, the Third Circuit made a basic legal error: It confused two different lines of equity cases, borrowing principles from one that have never been applied to the other. That is particularly inappropriate given this Court's warning in *Sereboff* to avoid conflating these very lines of authority. The decision below fails to honor the equitable principles applied in "the days of the divided bench," *Sereboff*, 547 U.S. at 363, and should be reversed.

III. THE DECISION BELOW THREATENS THE STABILITY OF SELF-FUNDED ERISA PLANS AND INCREASES THE BURDENS ON LITIGANTS AND COURTS.

Even setting aside the statute's text and purposes, as well as equitable principles long since settled, there are considerable policy reasons to reject the Third Circuit's rule. The rule would reduce reimbursement collections and pose a real threat to plan solvency. It would substantially increase litigation burdens on plans. It would unduly burden the courts. And it would encourage gamesmanship by participants, who could avoid reimbursement obligations by structuring third-party tort settlements to allocate only a de minimis portion to medical expenses. All of these incentives are antithetical to the policies underlying the statute.

A. The Third Circuit's Approach Discourages Employers From Offering Benefits.

1. As already discussed, the rule adopted below would substantially undermine the uniformity and predictability that Congress had in mind when it designed ERISA. See supra at 26-27. These are not mere abstract academic problems. On the contrary, this Court has observed that a "patchwork scheme of [judicial] regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 11 (1987).

The Third Circuit's opinion invites just that result. Estimates suggest that plans recover more than \$1 billion annually under reimbursement provisions. See Br. of Amicus Curiae America's Health Ins.

Plans, Inc. et al. in Support of Respondent, Sereboff, 547 U.S. 356 (No. 05-260), 2006 WL 460877, at *3 n.3. The rule adopted below will cost plans some portion of those reimbursements. And even a small increase in plan costs has potentially serious adverse effects: "[E]ach one percent increase in managed care plans' costs * * * results in a potential loss of insurance coverage for about 315,000 individuals." Health Economics Practice, Barents Group, LLC, Impacts of Four Legislative Provisions on Managed Care Consumers: 1999-2003, at iii (1998). 10

2. The Third Circuit rejected this argument out of hand. In response to the "practical concern" raised by Petitioner "that the application of equitable principles will increase plan costs and premiums," the panel wrote: "U.S. Airways cannot plausibly claim it charged lower premiums because it anticipated a windfall." Pet. App. 16a.

That response is doubly flawed. First, it turns a blind eye to the many authorities, set forth above, that recognize that "[r]eimbursement inures to the benefit of all participants and beneficiaries by reducing the total cost of the Plan." O'Hara, 604 F.3d at 1237-38 (emphasis added); see supra at 27-28. Indeed, even critics of plan reimbursement rights admit that reimbursement protects plan solvency: "[A]n insuring entity *** that receives substantial subrogated recoveries into its coffer will be financially healthier than one that lacks those recoveries." R.M. Baron, Public Policy Considerations Warranting Denial Of Reimbursement to ERISA Plans: It's Time to Recognize The Elephant In The Courtroom,

¹⁰ Available at http://www.uhia.net/web-storage/webstorage5/ Impact%20of%20Four%20Legislative%20Provisions%20-%20 Barrents%20Group.pdf.

55 Mercer L. Rev. 595, 630 (2004). It is far more than "plausibl[e]," Pet. App. 16a, that the constriction of reimbursement rights can lead to higher premiums. It is both obvious and widely recognized.

Second, the court's characterization of reimbursement recovery as a "windfall" is wrong. It bears repeating that employee benefit plans have the freedom to choose what benefits to offer, and the Plan here-like many others nationwide-chose to offer conditional benefits in cases like this one: The Plan pays up front, and the participant pays the Plan back if he recovers from a tortfeasor. Under that the first \$66,866 recovered by arrangement. McCutchen belonged to the Plan the moment McCutchen settled his case. As the Schwade court put it: "How can a plan obtain a 'windfall' by merely enforcing a contractual right that protects plan 'Windfall' assets? means unearned money: McCutchen's ERISA plan sought reimbursement of money paid by the plan and owed by McCutchen." 837 F. Supp. 2d at 1278.

Indeed, the Third Circuit's "windfall" rejoinder is particularly inapt in the context of a "self-funded" plan like the one here, in which the employer "does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants." FMC Corp., 498 U.S. at 54. Because self-funded plans cover their own costs and tend to be more exposed to the effects of a single catastrophic loss, "[r]eimbursement and subrogation provisions are crucial to the[ir] financial viability." Shank, 500 F.3d at 838. Thus, as even Respondents' preferred commentator has conceded, "in the self-funded plan scenario, *** there is no windfall as a result of the subrogated recovery." R.M. Baron, Subrogation: A

Pandora's Box Awaiting Closure, 41 S.D. L. Rev. 237, 260 (1996); cf. Brief in Opposition 31 n.8 (citing same article).

The Third Circuit's "windfall" observation may have resulted from the court's view that McCutchen would end up paying slightly more to the plan than his net recovery from the lawsuit-i.e., his recovery minus the later-negotiated attorney's fees. course, it is not at all clear that McCutchen's recovery actually would be "negative" in that narrow sense. (It could never be negative in the absence of attorney's fees, since the Plan is entitled only to reimbursement out of monies recovered.) The record on the net-recovery point is inconclusive, see supra at 10 & n.3, and Respondents themselves never advanced that argument below. But even assuming the accuracy of the Third Circuit's premise, there is nothing unfair about holding participants to their agreement in the rare case where the result is a negative recovery after attorney's fees. Plan participants and their attorneys typically control thirdparty tort litigation. They decide whether to sue and settle and on what terms, and how to structure fees. And they typically are aware very early in the thirdparty litigation of how much insurance is available to cover a tort claim. See Fed. R. Civ. P. 26(a)(1)(A)(iv) (requiring prompt production of "any insurance agreement under which an insurance business may be liable to satisfy all or part of a possible judgment Reimbursement provisions and in the action"). initial disclosure requirements thus put participants on notice of what they must recover to make litigation worth their while. As one district court explained: "[I]f the small size of the potential award leaves no attorney willing to share the beneficiary's

risk, this merely shows that the beneficiary correctly chose an immediate and safe benefit from the plan rather than an uncertain tort award (and the cumbrous, enervating, and expensive machinery of litigation) as the means of paying his medical bill." Schwade, 837 F. Supp. 2d at 1280.

Moreover, the purported "unfairness" is just as (if not more) likely to run in the other direction. Take, for example, the Ninth Circuit's recent decision in CGI. There the plan paid \$32,000 for a participant's medical expenses. The participant subsequently recovered \$376,906. Yet the participant refused to reimburse the plan on the theory that she had not been "made whole," and the panel agreed, remanding for the District Court to craft a remedy. 683 F.3d at 1116, 1124. That sort of outcome—patently unfair to plans, and contrary to ERISA's goals of certainty and plan solvency—will be the norm if Respondents' theory becomes law.

B. The Third Circuit's Rule Imposes Heavy Litigation Burdens On Plans And Courts.

The rule adopted below would not just cut down on reimbursements and make administration less predictable; it also would dramatically increase the litigation burden on plans and courts alike. That, too, undermines ERISA's core goals.

- 1. The Third Circuit's approach would multiply proceedings in reimbursement actions. To see why, consider the course of proceedings below in this case:
- Respondents argued that the Plan was entitled to the "portion of the injured beneficiary's underlying recovery that is reasonably allocable to those medical expenses that the ERISA plan actually paid, minus a proportional share of the costs and fees

accrued in recovering those expenses from a third party." Third Circuit Opening Br. 6.

- The Third Circuit instructed the District Court to consider "factors such as the distribution of the third-party recovery between McCutchen and his attorneys at Rosen Louik & Perry, the nature of their agreement, the work performed, and the allocation of costs and risks between the parties." Pet. App. 17a.
- The Third Circuit ordered the District Court to "engage in any additional fact-finding it finds necessary." Id. Likewise, the Ninth Circuit in CGI—the case that joined McCutchen in creating a circuit split—suggested that the district court would need to hold "further hearings and take further evidence" to determine what constituted "appropriate equitable relief" in that case. 683 F.3d at 1124.

The complications likely to arise under this approach are vast. After all, few of the factors set forth above are susceptible of easy resolution: What were the "overall damages" suffered by the participant? What proportion of his recovery was allocated to medical expenses? Were the attorney's fees reasonable? How does one determine "the allocation of costs and risks between the parties"? These questions would require federal courts to take additional evidence, and potentially to conduct additional hearings.

The "overall damages" inquiry would be particularly fraught with difficulty. Where the plaintiff has settled with the tortfeasor, no one knows if the settlement is the make-whole value of the plaintiff's claim or some compromised value representing the uncertainties of trial. See T.L. Fulks, The Made-Whole Doctrine: Its Effect on Tennessee Tort Litigation And Insurance Subrogation Rights, 32 U. Mem-

phis L. Rev. 87, 117-118 (2001). Faced with that problem in the context of state-regulated insurance (outside the purview of ERISA), some states have created a burdensome solution: a mini-trial between the plan member and plan, where the "trial court proceeds as it would in the damages phase of a normal bifurcated tort trial." Id. at 122-123 (citing Rimes v. State Farm Mut. Auto Ins. Co., 316 N.W.2d 348, 356 (Wis. 1982)). Thus even where beneficiaries had "settled their tort claims in order to eliminate the risks and burdens of litigation," the Third Circuit's approach "would necessitate that their claims nonetheless be litigated in the district court * * * to determine whether," among other things, the beneficiaries "were fully or only partially compensated by the * * * tort settlement." Harris, 208 F.3d at 281.

Similar complications would arise with any attempt to allocate attorney's fees. Under the typical "common fund" cost calculation, the attorney is entitled to a "reasonable fee under the circumstances"-but importantly, that fee is not "fixed by the terms of [the attorney's] contract with [the plan member]." Restatement (Third) of Restitution & Unjust Enrichment § 29 illus. 26 (2011). Thus, a federal judge in every case would need to determine an appropriate fee for the plan member's counsel by quantifying the nearly unquantifiable: "the value of the services" the plan member's attorney rendered to The Third Circuit has already the plan. Id.sketched out how this might work, telling the District Court to consider (among other things) "the distribution of the third-party recovery between McCutchen and his attorneys," "the nature of their agreement," and "the work performed." Pet. App. 17a. Such a nebulous test would flood the courts

with petitions to determine an attorney's reasonable fee in every tort case where the plaintiff is covered by a self-funded ERISA plan.

2. These factual inquiries would impose substantial burdens on plans, participants, and courts alike. The inquiries are not, after all, simple or mathematical; they are intensely factual and circumstance-specific, and they would embroil federal courts and litigants in resource-consuming litigation.

This Court already has rejected approaches to ERISA that have that effect. The Court explained in Conkright, for example, that ERISA "encourag[es] resolution of benefits disputes through internal administrative proceedings rather than costly litigation." 130 S. Ct. at 1649; accord FMC Corp., 498 U.S. at 65 (quoting 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits)) (ERISA is designed to "avoid 'endless litigation,'" not to multiply it). For that reason, the Court reviewed and reversed a decision that had the effect of "interject[ing] other additional issues into ERISA litigation," thereby "increas[ing] litigation costs." Conkright, 130 S. Ct. at 1649-50.

Indeed, the disapproving descriptions Conkright offered of the rule at issue there fit here, too. The Court wrote that respondents' rule would "weigh an indeterminate number of factors, which would only further complicate ERISA proceedings." Id. at 1650. And it wrote that the answer to the question respondents wanted to pose would rarely be "clear" and would "force the parties to litigate this * * * complicated * * * question." Id. The Third Circuit's rule can be described in the same terms. It would create multiple uncertainties. It would drive up litigation costs. And it would "unduly discourage employers

from offering welfare benefit plans in the first place." Varity, 516 U.S. at 497.

C. The Third Circuit's Rule Encourages Gamesmanship.

Finally, the Third Circuit's rule encourages gamesmanship by plan participants when they structure settlements with third-party tortfeasors. Take this case, for example: McCutchen argued not just that the Plan's reimbursement should be limited by the ratio of his recovery to what he had sought, but also that it should be limited to the portion of the recovery "that is reasonably allocable to the medical expenses that [the Plan] paid." Third Circuit Opening Br. 6. He argued, in other words, that if the recovery he obtained did not compensate him for his medical expenses, then the Plan would get nothing. The incentive this creates is obvious. As the United States recognized in its brief in Sereboff: "[T]he full reimbursement provision avoids the potential for strategic behavior in structuring a settlement by the insured and tortfeasor, who generally will have little reason to resist classifying damages as flowing from something other than medical costs." U.S. Sereboff Br., 2006 WL 460876, at *30 n.15.

* * *

Schwade examined the policy issues discussed above and summarized which way they cut: "If McCutchen's ungoverned notion of equity becomes pandemic, consistent plan operation becomes impossible, inconsistent judicial ruling becomes commonplace, and some beneficiaries become profiteers at the expense of others." 837 F. Supp. 2d at 1278-79. Exactly. The Third Circuit's decision does a disservice to plans and participants alike.

CONCLUSION

For the foregoing reasons, the decision below should be reversed.

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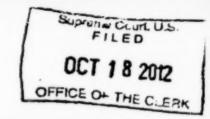
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August 2012

RESPONDENT'S BRIEF

No. 11-1285



IN THE

Supreme Court of the United States

U.S. AIRWAYS, INC., IN ITS CAPACITY AS FIDUCIARY AND PLAN ADMINISTRATOR OF THE U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN,

Petitioner.

V.

JAMES MCCUTCHEN AND ROSEN LOUIK & PERRY, P.C.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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QUESTION PRESENTED

Section 502(a)(3) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132(a)(3), authorizes a fiduciary, including an ERISA plan, to seek "appropriate equitable relief to. . . enforce any provisions of [ERISA] or the terms of the plan." This Court has previously held that this provision limits plans to relief that was "typically available" in equity. E.g., Mertens v. Hewitt Assocs., 508 U.S. 248, 256 (1993). In this case, an ERISA plan seeks reimbursement of medical expenses it paid from an injured beneficiary who recovered only a small fraction of his total damages from a tortfeasor. Based on the language of its plan, Petitioner argues that it is entitled to 100 percent reimbursement of its payments, regardless of the amount of the underlying recovery and without any deduction for attorney's fees or costs.

The question presented is whether ERISA plan reimbursement claims under § 502(a)(3) are subject to the following well-established equitable rules that prevent unjust enrichment:

- 1. The rule that prohibits insurers from recovering more than the amount of an insured's "double recovery."
- 2. The "common fund" rule that requires that those seeking to recover a portion of a fund pay a portion of the costs and attorney's fees incurred in obtaining that fund.

RULE 29.6 DISCLOSURE STATEMENT

Respondent Rosen Louik & Perry is a professional corporation. Rosen Louik & Perry does not have any parent companies, and there is no publicly held corporation that owns 10 percent or more of its stock.

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INTRODUCTION

James McCutchen worked as an airline mechanic for 18 years until his career was cut short by a car crash that left him permanently disabled and in chronic pain. His employer, Petitioner U.S. Airways, paid his medical expenses, as required by his ERISA plan, for which he had paid premiums throughout his employment.

U.S. Airways had the right to sue the tortfeasor directly to recover its insurance payments. But U.S. Airways instead chose to sit back and wait to see how Mr. McCutchen fared in his own effort to recover from the driver. With the help of his attorneys, Mr. McCutchen was able to recover some money for his injuries, but due to the limited assets and insurance of the teenage driver who hit him, it was only a tiny fraction of his total damages. Nevertheless, U.S. Airways then sued Mr. McCutchen and his attorneys in federal court, seeking to recover out of Mr. McCutchen's recovery all of the money it paid for his medical expenses, without any deduction for a portion of the costs or fees required to generate the recovery.

The law does not permit this result. U.S. Airways' suit was brought under a federal statute—§ 502(a)(3) of ERISA—that gives fiduciaries like U.S Airways the right to seek "appropriate equitable relief." In the days of the divided bench, when courts of equity considered reimbursement claims in the insurance context, those courts applied the principle of unjust enrichment in two concrete ways: to limit double recoveries by the insured and to make sure that attorneys were compensated by all beneficiaries of

the recovered sum. This was true whether or not the right to reimbursement was articulated in an agreement.

U.S. Airways repeatedly insists, however, that, although ERISA limits its relief to what was recoverable in equity, it is entitled to recover whatever its unilaterally drafted subrogation clause says it is entitled to—which, here, is 100 percent of the medical expenses it covered. In other words, Petitioner asks this Court to treat its equitable claim as if it arose in law.

This approach is neither "appropriate" nor "equitable." In reality, every equitable authority says that claims just like Petitioner's must be measured according to the equitable principle of unjust enrichment, not by rote enforcement of contract terms. That is the only approach consistent with all the language of the governing statute; it is the approach adopted by the lower court; and it is the approach that should be affirmed by this Court.

Ultimately, what U.S. Airways seeks is a rule that would liberate ERISA plans from the sort of limitations applicable to reimbursement claims in virtually every other reimbursement context, including Medicare, Medicaid, and state insurance regimes. If this Court agrees with Petitioner, ERISA will become the only place where insurers are free to recover whatever relief they write into their plans, regardless of the extent to which injury victims have been compensated for the full range of their injuries, and without contributing a penny to costs or fees. In the context of a statute with the primary purpose of

protecting plan participants and beneficiaries, this cannot have been the result intended by Congress.

STATEMENT

A. Statutory Background.

In passing ERISA, "the crucible of congressional concern was misuse and mismanagement of plan assets by plan administrators." Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 140 n.8 (1985). Congress's primary goal was to "protect . . . the interests of participants in employee benefit plans . . . [by] providing for appropriate remedies " 29 U.S.C. § 1001(b). As this Court has stated, "Congress' desire to offer employees enhanced protection for their benefits" "outweighed" other considerations, including reduction of costs associated with ERISA a plans. Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 113-14 (2008); see also Varity Corp. v. Howe, 516 U.S. 489, 513 (1996) (holding that ERISA's "basic the purposes" of "protect[ing] interests participants and beneficiaries" trump "the need for a sensible administrative system," which was, at most, a "subsidiary congressional purpose").

One way Congress sought to achieve this goal was by passing a set of "carefully integrated civil enforcement provisions," which conferred different rights to relief on different categories of plaintiffs for violations of the statute. Russell, 473 U.S. at 146-47. Under this scheme, plan fiduciaries are limited to seeking "appropriate equitable relief" under ERISA § 502(a)(3). This term has been interpreted to mean that plans are limited to seeking only that relief that was "typically available in equity." Mertens v. Hewitt

Assocs., 508 U.S. 248, 256 (1993) (emphasis in original)

In 2006, this Court decided Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356, 361 (2006), which considered whether an ERISA plan's reimbursement claim could be brought under § 502(a)(3). Sereboff clarified that two key questions lie at the heart of any inquiry into the meaning of §502(a)(3): (1) whether a party's claim qualifies as "equitable" within the meaning of the statute; and (2) whether the relief a party seeks on that claim would have been "appropriate" in equity. Id. at 361-63.

In Sereboff, the Court's analysis was limited to the first of these questions. See id. at 363. After canvassing the relevant authority, this Court held that the plan's claim—arising from an express subrogation agreement and tied to a to-be-created fund—was cognizable in equity because it was "indistinguishable from an action to enforce an equitable lien established by agreement." Id. at 364-68. Having determined that the claim qualified as equitable under § 502(a)(3), this Court then declined to decide what relief would have been "appropriate" in the days of the divided bench, because that issue had not been preserved below. Id. at 368 n.2.

B. This Litigation.

1. In early 2007, James McCutchen was grievously injured when "a young driver lost control of her car, crossed the median of the road, and struck" Mr. McCutchen's vehicle. Pet. App. 3a. The accident was tragic; one of the four teenage passengers in the young driver's car was killed and

two suffered traumatic brain injuries. Joint Appendix ("JA") 40, 61. Mr. McCutchen survived only after emergency surgery and subsequently required extensive medical care. *Id.* at 61-62. He remains permanently disabled and suffers from chronic pain that cannot be relieved with medication. *Id.*

Uncontroverted evidence established that Mr. McCutchen's and his wife's total damages from the accident were between \$1 million and \$1.75 million. Pet. App. 29a. In addition to past medical expenses of \$66,866, Mr. McCutchen suffered economic damages for past lost wages, future lost wages, and loss of earning capacity, and non-economic damages for pain and suffering, loss of enjoyment of life, and disfigurement. Mrs. McCutchen suffered loss of consortium. See JA 60-62.

Mr. McCutchen's health benefit plan, administered by U.S. Airways (the "Plan"), paid his medical expenses of \$66,866. Pet. App. 3a. The policy under which the Plan paid Mr. McCutchen's medical expenses was not negotiated or signed by Mr. McCutchen. Under its terms, the Plan was obliged to pay Mr. McCutchen's medical bills regardless of whether (1) his injuries were caused by a third-party and (2) he would later decide to pursue relief against a third party. *Id.* at 4a.

Several months after the accident, the McCutchens retained a law firm, Respondent Rosen Louik & Perry, P.C., to represent them in a claim against the driver. With the firm's help, the McCutchens also made a claim for underinsurance coverage from their own separate automobile policy

because the driver had limited assets and liability coverage to compensate all four people injured in the accident. *Id.* at 3a.

On June 26, 2007, one of Mr. McCutchen's lawyers, Jon Perry, was contacted by Ingenix Subrogation Services, which informed Mr. Perry that it had been hired by United Healthcare to pursue a subrogation/reimbursement claim against Mr. McCutchen should he recover for his injuries. JA 42. The letter claimed that the Plan was governed by ERISA and that it was entitled to "a subrogation and/or reimbursement interest in this matter under applicable law." Id. at 42-43. It also instructed that "[o]nce settlement funds come into your possession, you should hold them in trust until such time as our client's interest has been severed from the interest of your client." Id. at 43.

Mr. Perry replied that same day, asking Ingenix to provide documentation that the Plan was in fact governed by ERISA and "self-funded." He also asked for a "complete copy of the plan or trust document." Id. at 44-45. This information was important because, if the Plan was governed by state law, its claim would have been barred by a Pennsylvania statute prohibiting insurers from seeking reimbursement from persons injured in motor vehicle accidents. See 75 Pa. Cons. Stat. § 1720.1

¹ Until recently, Respondents had never seen the Plan that Petitioner claims governs this case, despite repeated requests that it be provided to them. The governing Plan was finally provided to all parties in June 2012, after this Court granted review, in response to a request from the Office of the Solicitor (Footnote continued)

Ingenix provided neither a copy of the plan nor adequate documentation that it was self-funded. After waiting almost a year, on April 24, 2008 Mr. Perry contacted Ingenix again. JA 46-47. This time. he notified Ingenix that he and the other injured parties were trying to settle their claims out of what little money existed from the tortfeasor's insurance. He explained that "the accident at issue in this case involved multiple claimants with a very limited amount of insurance possessed by the at-fault driver," and he included correspondence detailing the proposed payments to the four claimants. Id. at 46-49. Mr. Perry further explained that, because the other injury victims were even worse off than Mr. McCutchen, the proposal allotted him only \$10,000. Given the wholly "inadequate proceeds," Mr. Perry asked Ingenix to waive any alleged lien. Id. at 46-47. In a later letter, Mr. Perry also advised Ingenix that, although he planned to pursue a recovery out of Mr. McCutchen's own underinsured motorist ("UIM") policy, the Plan was not entitled to assert a lien on that claim under Pennsylvania law. Id. at 50.

Ingenix never answered whether the Plan would waive any lien claim, prompting Mr. Perry to send another letter, on July 3, 2008, imploring Ingenix to respond so that he could settle the underlying claim with the other claimants. "As you can see," Mr. Perry

General of the United States. As it turns out, the express subrogation clause in the Plan contains several material differences from how that clause is explained in the Summary Plan Description. Whether these differences establish a basis for reformation under § 502(a)(3) is an issue to be explored on remand. See CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1871 (2011).

explained, another claimant's attorney has "now threatened to move to impose sanctions on me for the unreasonable delay in resolving this matter. This matter remains unresolved because you have failed to respond to my prior correspondence relating to your alleged lien." *Id.* at 52.

With no other option, and still having heard nothing from Ingenix, Mr. Perry agreed to the proposed settlement, which allotted Mr. McCutchen only \$10,000 for his injuries. He also successfully settled the McCutchens' UIM claim for policy limits of \$100,000. He then sent a letter to Ingenix, advising it that that he had "resolved Mr. McCutchen's case for a payment of \$10,000" and requesting that he be notified if the Plan still intended to assert a lien. Id. at 56.

Three months later, Mr. Perry received a notice from Ingenix that it was in fact asserting an alleged lien on Mr. McCutchen's combined recovery of \$110,000—\$10,000 from the tortfeasor's insurance and \$100,000 from his own UIM policy—which amounted to, at most, 11% of his total damages. See Id. at 58.2 Mr. Perry responded with yet another request for documentation substantiating the Plan's right to assert a lien. Id. at 58-59. Mr. Perry nonetheless escrowed \$41,500 in his account, the amount of the Plan's asserted claim less a 40%

² \$110,000 is 11% of \$1 million, the low-end estimate of the uncontroverted value of Mr. McCutchen's injuries. See Pet. App. 29a.

deduction for fees and expenses that should be borne by the Plan. Id.3

2. U.S. Airways then sued Mr. McCutchen and his lawyers in the Western District of Pennsylvania, seeking a constructive trust or equitable lien on the \$41,500 held in trust by Mr. Perry and the remaining \$25,366 personally from Mr. McCutchen. Pet. App. 4a. U.S. Airways based its claim for reimbursement on a provision in the Summary Plan Description that stated, among other things, that "[y]ou will be required to reimburse the Plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, your own insurance company." Id. U.S. Airways argued that, under this language, the court was required to award the Plan 100 percent of the money it paid for medical expenses without deduction for the costs and fees incurred in obtaining that sum.

The district court granted U.S. Airways' request for 100% reimbursement, holding that it was duty-bound, under "established precedent of the Third Circuit" decided prior to this Court's decision in Sereboff, 547 U.S. 356, to apply contract law in measuring the award. Pet. App. 30a.

3. A unanimous panel of the Third Circuit reversed, holding that the phrase "appropriate

³ In light of the severity of Mr. McCutchen's injuries and his inadequate legal recovery, his attorneys ultimately decided to refund their fee, although they had a contractual right to forty percent of the recovery. That decision has no bearing on whether the Plan must share in the costs and fees incurred in obtaining the portion of the funds it seeks.

equitable relief in § 502(a)(3) means "more than just that the relief [an ERISA Plan] seeks must be of an equitable type; courts must also exercise their discretion to limit that relief to what is 'appropriate' under traditional equitable principles." Id. at 9a (emphasis added).

In reaching this conclusion, the Third Circuit followed the roadmap set out by this Court's trilogy of § 502(a)(3) cases—Mertens, 508 U.S. 248, Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002), and Sereboff—to determine whether the measure of relief sought by the Plan was "appropriate" in light of the "equitable principles and defenses that were typically applied." Pet. App. 10a-12a. It held that the district court had improperly discarded the treatises relied on by this Court in all of its § 502(a)(3) cases, which "all support [the] . . . position that the principle of unjust enrichment" applies to Petitioner's claim. Id. at 11a.

The court of appeals ultimately held that a judgment requiring Mr. McCutchen to provide full reimbursement to U.S. Airways "constitutes inappropriate' and inequitable relief." Id. at 16a. "Because the amount of the judgment exceeds the net amount of McCutchen's third-party recovery," the court observed, the judgment "leaves him with less than full payment for his emergency medical bills, thus undermining the entire purpose of the Plan." Id. "At the same time," awarding full reimbursement to the Plan would amount "to a windfall for U.S. Airways, which did not exercise its subrogation rights or contribute to the cost of obtaining the third-party recovery." Id.

Concluding that "[e]quity abhors a windfall," id., the Third Circuit vacated the district court's final judgment granting 100 percent reimbursement to U.S. Airways and remanded for a determination of what relief would be appropriate under relevant equitable principles.

SUMMARY OF ARGUMENT

A claim brought under § 502(a)(3) of ERISA turns on equity, not contract. The question in this case, then, is how courts would have treated claims like Petitioner's in the days of the divided bench.

In equity, where—as here—an insurer attempted to recover tort proceeds from an injured beneficiary. the insurer's potential relief was limited in two key respects, both based on the principle of unjust enrichment. First, where the beneficiary suffered damages beyond those covered by insurance, the insurer could only recover, at most, the share of the proceeds that compensated the beneficiary for losses paid for by the insurer—an amount equivalent to the beneficiary's "double recovery." Second, where the proceeds were generated by the efforts of the beneficiary's attorney, the insurer had to pay a proportionate share of the costs incurred in creating the "common fund," including attorney's fees. Absent fraud or other improper conduct on the part of the insured, those were the "appropriate" limits equity of subrogation type on everv reimbursement claim made in equity by an insurer.

Petitioner tries to avoid these principles by attempting to divorce this case from subrogation. Petitioner's truncated analysis of historical equity is that (1) in equitable lien cases not involving subrogation, (2) equitable limits on subrogatory relief were not mentioned, so therefore (3) equitable liens are free from subrogatory limits. No credible authority concurs.

In reality, in cases involving tort subrogation, limiting rules such as "double recovery" and "common fund" were not suspended simply because the insurer sought to enforce its equitable right through an "equitable lien by agreement." Indeed, irrespective of the remedial vehicle used to invoke equity jurisdiction—including, yes, equitable liens by agreement—the authorities are quite clear that the available relief was subject to double recovery and common fund limits. To conclude otherwise would be to wipe out entire chapters of what equity courts considered appropriate relief.

Ultimately, Petitioner seeks to pervert ERISA's enforcement scheme by enforcing whatever terms it writes into an ERISA plan, regardless of equity's view of those terms, and to obtain a judgment for contractual damages against an individual for breach. This sort of relief has a name—"contractual legal relief"—and whatever the appeal of contractual relief, it is not contemplated by § 502(a)(3). To be sure, § 502(a)(3) contains a reference to the "terms of the plan," but that language governs the types of claims a plan can bring and does not override the fact that § 502(a)(3) limits the relief to "appropriate equitable relief."

In this respect, the Legislature's will must be followed regardless of Petitioner's policy concerns about the result. In any event, those concerns are unsubstantiated. Petitioner and its numerous amici have offered no evidence that the lower court's approach will wreak havoc on ERISA plans. This alone is reason enough to reject their conjecture and scare tactics. Additionally, the available evidence reveals that the Third Circuit's approach, which simply authorizes courts to apply the same rules that have always applied to subrogation cases in equity, will not have any substantial impact on either ERISA plans or beneficiaries.

At base, Petitioner's hyperbole should be dismissed for what it is: an attempt to hide the fact that a claim for 100 percent reimbursement against an injured beneficiary who has only recovered a fraction of his damages is not "appropriate equitable relief" within the meaning of § 502(a)(3).

ARGUMENT

THE DECISION BELOW IS FAITHFUL TO ERISA, HISTORICAL PRINCIPLES OF EQUITY, AND PUBLIC POLICY.

I. The Third Circuit's Approach Is Consistent with How Petitioner's Claim Would Have Been Measured In the Days of the Divided Bench.

This case is about "subrogation," a term used to describe the right of an insurer to either (1) stand in the shoes of the insured on a claim for compensation against a third party, usually a tortfeasor, or (2) directly pursue repayment against an insured who has recovered compensation from a third party. See

29A Am. Jur. Subrogation § 1719, at 797-98 (1962); id. § 1736, at 812-13.4

Petitioner, an insurer, paid Mr. McCutchen, an insured, for medical losses he suffered under an insurance policy that contains an express subrogation provision, which by its terms authorizes the Plan to exercise either of the above rights. In this case, Petitioner opted for the latter, pursuing reimbursement directly against Mr. McCutchen. But whether an insurer chooses to sue a tortfeasor directly, or—as here—waits to seek reimbursement from an insured's third-party recovery, the insurer's relief is measured by the same specific equitable rules that applied to all subrogation-based claims. *Knudson*, 534 U.S. at 204 n.1.

A brief word about terminology: As one scholar has observed, "For those who do not often visit the field of subrogation, the basic terminology can be confusing to the point of frustration." 16 Couch on Insurance 3d § 222:2 (L. Ross & T. Segalla eds., 3d ed. 2012). Generally speaking, "subrogation" is an umbrella term that encompasses several distinct, but related, rights. First, an insurer has the right to pursue relief directly against a third party to recover expenses paid on behalf of an insured. That right is typically—and confusingly—called "subrogation." Id. Second, in cases where—as here—an injured beneficiary has alone pursued relief directly against a tortfeasor, the insurer has the right to pursue repayment from the insured after the underlying case has been concluded. That right is typically called "reimbursement," although it falls under the umbrella use of the term "subrogation." Id. In equity and still today, the two doctrines are functionally intertwined, and, for present purposes are governed by the same controlling principles. See Newcomb v. Cincinnati Ins. Co., 22 Ohio St. 382 (Ohio 1872); 73 Am. Jur. 2d Subrogation § 6 (2012).

A. In Equity, All Subrogation-Based Claims Were Capped by the Amount of an Insured's Double Recovery.

1. At its most fundamental level, the doctrine of subrogation embodies a desire to ensure parity between three related parties—a tortfeasor. injured beneficiary (often referred to as an "insured"), and an insurer—by allowing the insurer to recoup money it paid out on its beneficiary's behalf, either by suing the tortfeasor directly or (as in this case) seeking reimbursement from the beneficiary in the event he recovers damages from the tortfeasor. See generally 174 John Appleman & Jean Appleman, Insurance Law and Practice § 4054, at 142-46 (1981); 16 Couch on Insurance 2d § 61:18, at 93-96 (Rev. ed. 1983); 4 G. Palmer, Law of Restitution § 23.16(b), at 444-48 (1978).

insurer's rights of subrogation reimbursement can arise in one of two ways: either (1) contractually, when the insurer's subrogation and reimbursement rights were provided for agreement, or (2) impliedly, where, in the absence of an express agreement, an insurer who has paid some loss under a policy may then later seek to recover for that payment. 29A Am. Jur. Subrogation § 1719, at 797-98; see id. at § 1736, at 812. (The implied right of subrogation is sometimes referred to "freestanding" subrogation claim. See Sereboff, 547 U.S. at 368 (distinguishing between an implied, or "freestanding," subrogation claim and one based on an "express agreement")). Either way, because these rights were "properly a matter of equitable cognizance," a party who sought to enforce a

subrogation-based right typically did so in a court of equity. See 60 C.J. § 125. And, as explained below, the same principles applied to the relief available for all subrogation and reimbursement claims presented in equity, regardless of whether they were based on a written agreement.

2. In equity, subject to certain limits not relevant here, one key rule governed all subrogation-based claims between an insurer and insured: the principle of unjust enrichment, which limited the insurer to recovering no more than the amount of the insured's double recovery. See 16 Couch on Insurance 3d, supra, § 222:8 (explaining that the doctrine of subrogation "has the objective of preventing the insured from recovering twice for one harm"); see 174 Appleman, supra, § 4054, at 143 (noting that the doctrine "rests on maxim that no one should be enriched by another's loss").

"Double recovery" is said to occur when an injured beneficiary recovers money from both his insurer and a third party, such as a tortfeasor, for the same loss, for example, medical expenses. For reimbursement claims, the rule capping an insurer's recovery at the amount of the insured's double recovery means an insurer can recover no more than the "part of the recovery which the claimant establishes was in compensation for the same loss." 4 Palmer, supra, § 23.16(b), at 444.5

⁵ This rule dates back centuries. See, e.g., Randal v. Cockran, 27 Eng. Rep. 916, 916 (1748) (explaining that once the insurer provided payment for loss, "the assured stands as a (Footnote continued)

In a case where the injured party is fully compensated for all of his damages, the doublerecovery rule does not limit the insurer's recovery in any respect. Thus, for example, assume a case in which an injured beneficiary incurs \$10,000 in medical expenses, which are paid by his insurance plan. He then sues the tortfeasor and ultimately amount-say, \$50,000—that recovers compensates him fully for all his damages, which include (for example) both medical expenses and loss of future earnings. In that situation, because the beneficiary was fully compensated for his injuries, his "double recovery" consists of the full amount of his medical expenses—\$10,000—which he recovered from both his insurer and the tortfeasor. In equity, this is the amount the insurer would be entitled to recover, minus its fair share of attorneys' fees and costs. See, e.g., 176 Appleman, supra, § 4096, at 283.6

But in cases where the injury victim only recovers a fraction of his total damages (where, for example, multiple claims have been made against the wrongdoer, or the wrongdoer is insolvent), or where he recovers for other damages unrelated to the insurer's payments, application of the double recovery rule means that the insurer is only entitled

trustee for the insurer, in proportion for what he paid" for any losses "restored in specie or compensation made for them"); Comegys v. Vasse, 26 U.S. 193, 214 (1828) ("Whatever may be afterwards recovered or received . . . as a compensation for the loss, belongs to the underwriters.") (emphasis added).

⁶ The deduction of attorney's fees and costs is pursuant to the common fund doctrine, a separate equitable principle discussed below at Part I.B.

to recover the portion of the recovery that was covered by the insurance policy. See id. at 287 (explaining that the insured is "only liable for the insurer's pro rata share of a recovery . . . where the insured has also recovered for other items of damage"); 29A Am. Jur. Subrogation § 1739, at 815 (explaining that, although an insurer has "a right to share in the proceeds of a recovery against or settlement with the tortfeasor in favor of the insured," that right does not permit recovery of proceeds that "represent the satisfaction" of the insured's other losses); 16 Couch on Insurance 2d, supra, § 61:29, at 111-12 ("[W]hen the insurer is partially subrogated by virtue of having paid the property damage of the insured and the latter then brings an action for both property and personal damage, the insured holds that part of the fund recovered which represents the damages to the car as a trustee for the benefit for the insurer.") (emphasis added).

Example: Assume, in the above case, that the injured beneficiary recovers only one-half of his total damages from the tortfeasor (\$25,000, in the above example) due to, say, limited insurance. In that instance, the double recovery rule would limit the insurer's recovery to that portion of the fund that compensated for the medical expenses, minus a proportionate share of costs and fees. This apportionment ensures that the insurer only recovers to the extent that the beneficiary has been

"unjustly enriched" by recovering twice for the element of damage covered by the insurance.7

3. This limitation on an insurer's recovery, importantly, applied regardless of whether a subrogation claim was based on an express agreement or simply arose by virtue of payment. So long as an insurer seeks to recoup insurance proceeds in equity—whether its action sprung from a written agreement or not—its relief was subject to the double recovery limitation rooted in equity's prohibition against unjust enrichment. See 16 Couch on Insurance 2d, supra, § 61:20, at 98 (explaining

⁷ In practice, courts applied one of several approaches to measuring an insured's double recovery, including (1) an approach that limited insurers to a pro rata share of advanced medical expenses, measured by comparing the insured's recovery with his total damages, see, e.g., 176 Appleman, supra, § 4906, at 287, and (2) a rule of proof method, in which a court might use a rebuttable presumption that the fund either did or did not amount to compensation for insured harms, subject to rebuttal by either the insurer or the insured. See 29A Am. Jur. Subrogation §1739, at 815; 4 Palmer, supra, §23.16(b), at 444; see also Peterson v. Ohio Farmers Ins. Co., 191 N.E.2d 157 (Ohio 1963). (As explained below, the "make-whole" rule is sometimes viewed as another variant of the double recovery rule, but Respondents are not urging its application here.) Importantly, none of the accepted approaches involved doing what Petitioner contends a court must do, which is to refer exclusively to the terms of the subrogation provision. That view transforms the nature of relief from one based on an insured's double recovery to one based on an insurer's loss under the contract. Nonetheless, which approach is appropriate here, and how a court will ascertain how much of Mr. McCutchen's recovery constitutes compensation for losses paid by Petitioner, are questions properly left for the district court on remand. See CIGNA, 131 S. Ct. at 1880.

that subrogation-based rights "remain[] basically equitable in character, and hence, subrogation is to be accorded upon equitable principles even though the right thereto . . . is contractually declared.") (emphasis added); 6A Appleman, supra, § 6503, at 441 (observing that subrogation-based rights are "required to be so administered as to secure real and essential justice without regard to form, and is deemed to be independent of any contractual relations between the parties affected") (emphasis added).

Indeed, the leading treatise on restitution, cited by this Court in Sereboff, 547 U.S. at 368, states that the "principle of unjust enrichment," in the form of a rule capping an insurer's recovery to the insured's double recovery, applies across the board to subrogation-based claims brought in a court of equity. See 4 Palmer, supra, § 23.18(d), at 470 (principle of unjust enrichment applies to freestanding subrogation-based claims) with id. at 472-74 ("that same principle" applies to claims based on express subrogation agreement).8

In some cases, equity courts permitted an insurer to modify the timing of its right to pursue subrogation. Compare Morrow v. U.S. Mortgage Co., 96 Ind. 21, 26-27 (1884) with Home Ins. Co. v. Hartshorn, 91 So. 1, 2 (Miss. 1922). In others, an insurer was permitted to pursue its reimbursement claim in a court of law, seeking damages on a breach of contract theory. See, e.g., Ill. Auto. Ins. Exch. v. Braun, 124 A. 691 (Pa. 1924); Universal Ins. Co. v. Millside Farms, Inc., 197 A. 648, 649-50 (N.J. 1938); Home Ins. Co. v. Bernstein, 16 N.Y.S.2d 45, 48-49 (N.Y. Mun. Ct. 1939); James v. Emmco Ins. Co., 30 S.E.2d 361 (Ga. Ct. App. 1944). In Braun, for example, the court allowed the insurer to (Footnote continued)

So-whether an insurer brought a freestanding claim for reimbursement or a claim based on an express subrogation clause—if that claim was in equity, the insurer could not have recovered any more than the part of the recovery that was in compensation for the loss it had paid. This held true in medical insurance cases no less than in property insurance cases. Compare id. at 474 ("[T]he insurer's claim should be limited to the net amount recovered by the insured for medical expense.") (emphasis added) with 29A Am. Jur. Subrogation § 1739 (the insurer's claim is limited to the amount recovered for "damages to the insured property"); see also 4 Palmer, supra, § 23.18(d), at 473-74 (the double recovery rule "should serve to limit the effectiveness of contract provisions which in terms provide for reimbursement out of the insured's tort recovery without regard to whether or the extent to which, that recovery includes medical expense").

Cases prior to the law-equity merger consistently applied this rule to subrogation claims based on an express subrogation clause, even where that clause expressly sought to disclaim this limit. In Svea Assurance Co. v. Packham, 92 Md. 464 (1901), for example, an insurer's express subrogation clause

recover damages under its policy (which contained a subrogation clause) where the insured had settled with the wrongdoer without giving notice to the insurer. 124 A. at 692; see generally 51 A.L.R. 2d 697, at § 4 (1957) (discussing Braun and other cases). In this case, because Petitioner's claim arises under § 502(a)(3), it may not pursue a claim for damages under a contract.

authorized recovery to "the extent of [its] payment" from "all right[s] of recovery by the insured." Id. at 360. The insurer argued that this clause defeated the double recovery cap and entitled it to recover everything it had paid to the insured. Id. The court refused to award the insurer this relief, explaining that, because only a portion of the underlying settlement compensated for the losses covered by the insurer, the insurer was limited to recovering no "more than its proportion of the amount recovered, after deducting costs and expenses." Id. at 363. "It would be very inequitable," the court admonished, to permit the insurer to "refuse to take part in a suit brought by the insured," let him settle "for an agreed amount," and then "come into a court of equity and exact payment in full of him, when the others only get a part." Id.; see also Knaffl v. Knoxville Banking & Trust Co., 182 S.W. 232, 233 (Tenn. 1916); Fire Ass'n of Phila, v. Wells, 84 N.J. Eq. 484, 486 (N.J. 1915); Camden Fire Ins. Ass'n v. Prezioso, 93 N.J. Eq. 318 (N.J. Ch. 1922).

Petitioner's approach here was no different than that of the insurer in Svea. As in that case, Petitioner was informed of the underlying case but refused to respond when asked repeatedly whether it planned to assert or waive its lien (it even refused to prove that it had an enforceable lien). Petitioner then argued that its express subrogation clause should override the reimbursement limits that would typically have applied to its relief. No court in equity would have allowed it to so profit. See Svea, 92 Md. at 363 (rejecting insurer's attempt to "seek to profit by its refusal to take part in that proceeding, on the theory that it was not a party to the settlement, and

hence is not bound by it"); see also Shawnee Fire Ins. Co. v. Cosgrove, 116 P. 819, 820 (Kan. 1911) (holding that where insurer made no effort to intervene, it could not hold the insured responsible for settling the case as he thought best); but see Peterson, 175 Ohio St. at 38 (permitting 100 percent reimbursement based on express subrogation agreement where insurer "cooperat[ed] and assisted in proceedings against the wrongdoer").

Courts that still sit in equity continue to apply the double recovery cap on an insurer's relief. For instance, the Supreme Court of Tennessee, reviewing an equity court, was presented with a subrogation provision that purportedly gave the insurer the right to recover everything it paid even though the insured had not obtained a double recovery. The court held that, because the insurer's claim for reimbursement sounded in equity, it could not defeat those equitable principles by contract, on the ground that "[t]he purpose of insurance subrogation is to prevent either the unjust enrichment of the insured through a double recovery or a windfall benefit to the principal tortfeasor." Wimberly v. Am. Cas. Co. of Reading, Pa. (CNA), 584 S.W.2d 200, 203 (Tenn. 1979); see also N. River Ins. Co. v. McKenzie, 74 So.2d 599, 605-06 (Ala. 1954) (explaining that absent fraud by insured, insurer's recovery from insured's settlement limited to amount awarded for damages covered by the insurance contract); Emp'r's Liab. Assur. Corp., Ltd., of London v. Daley, 51 N.Y.S.2d 567, 570 (N.Y. Sup. Ct. 1944) (explaining that insurer has no right of subrogation for damages claims other than the types of damages covered by the insurance contract).

The double recovery cap was in fact so wellestablished that many courts of law have applied this limit on relief to legal claims for reimbursement. See, e.g., Am. Auto, Ins. Co. v. Seaboard Surety Co., 318 P.2d 84, 87 (Cal. Dist. Ct. App. 1957) ("The principle of equitable subrogation overrides the terms of the insurance policies."); Miller v. Liberty Mut. Life Ins. Co., 48 Misc. 2d 102, 107, 264 N.Y.S.2d 319 (N.Y. Sup. Ct. 1965), aff'd mem. 289 N.Y.S.2d 726 (1968) (limiting insurer to only those settlement proceeds allocable to medical expenses despite agreement claiming right to recover "the proceeds of any settlement or judgment"); DeCespedes v. Prudence Mut. Cas. Co., 193 So.2d 224, 227 (Fla. App. 1966), aff'd 202 So.2d 561 (Fla. 1967) ("So long as subrogation, as applied to this medical pay provision, serves to bar double recovery, it should be upheld."); Aetna Life & Cas. Co. v. Nelson, 492 N.E.2d 386, 390 (N.Y. 1986) ("IIIn cases where an injured person, who has obtained reimbursement for medical expenses from an insurer, is subsequently reimbursed by the tort-feasor for the same injuries, a lien attaches on behalf of the insurer to that portion of the recovery.").9

Some courts and state legislatures have, in the interest of protecting insureds, elected to apply the

⁹ The rare circumstances in which courts refused to apply the double recovery cap to an insurer's claim for reimbursement have no bearing on this case. These exceptions were largely limited to cases of fraud or gamesmanship on behalf of the insured, e.g., N. River Ins. Co., 74 So.2d at 605 (fraud); Hayward v. State Farm Mut. Auto Ins. Co., 4 N.W. 2d 316 (Minn. 1942) (same), which did not occur here.

"double recovery" cap after an insured has first recovered all of its losses, so that an insurer could only recover in cases where the insured has been made whole for his injuries. See, e.g., Washtenaw Mut. Fire Ins. Co. v. Budd. 175 N.W. 231, 232 (Mich. 1919). These decisions, adopting what is known as the "make-whole rule," do not change the overall ceiling on an insurer's recovery, which remains the amount of an insured's "double recovery"; they simply change when that measure will be applied (only after the insured has recovered its damages). In this case. Respondents have not pressed application of the make-whole rule, arguing only that Petitioner's recovery must be capped by the measure of Mr. McCutchen's double recovery, the traditional ceiling on an insurer's recovery under any subrogation-based claim in equity.

Were Petitioner's contrary view correct—that is, if the assertion of an equitable lien based on an express subrogation agreement would be free of all equitable limitations—then every lawyer over the past two centuries who sought reimbursement based on an express subrogation clause could have defeated equity's rules simply by styling the claim as one for an "equitable lien by agreement." This did not happen because it was well understood that an equity court would apply the double recovery cap no matter how the claim was styled, so long as it was brought as an exclusively equitable claim. Because Petitioner's claim is, by necessity, exclusively equitable (otherwise it would not be cognizable under § 502(a)(3)), that cap necessarily applies in this case.

B. In Equity, Every Claimant Who Stands to Benefit from the Creation of a Common Fund Must Pay Its Proportional Share of the Fees and Costs Incurred to Create the Fund.

The second rule of limitation applicable to Petitioner's claim is one of the most well-settled rules in equity: the common fund rule. "Since the decisions in Trustees v. Greenough, 105 U.S. 527 (1881), and Central RR & Banking Co. v. Pettus, 113 U.S. 116 (1885), this Court has recognized consistently that a litigant or a lawyer who recovers a common fund for the benefit of persons other than himself or his client is entitled to a reasonable attorney's fee from the fund as whole." Boeing Co. v. Van Gemert, 444 U.S. 472, 478 (1980) (citations omitted).

- 1. Like the double recovery cap, the common fund rule rests on the principle of unjust enrichment. See id. at 478; Mills v. Elec. Auto-Lite Co., 396 U.S. 375, 392 (1970). And, because this rule "reflects the traditional practice in courts of equity," Boeing, 444 U.S. at 478, a court sitting in equity possesses the authority to apply it "in any situation in which the work of the attorney has produced a fund . . . and in which the benefits are accepted by others." 1 Dobbs, D., Law of Remedies, § 3.10(2), at 393 (2d ed. 1993). When that occurs, "those who share in the fund . . . are therefore responsible for a proportionate part of the attorney fee and other reasonable costs of litigation." Id. at 393; Boeing, 444 U.S. at 478.
- 2. Although the common fund doctrine has been applied in a number of different settings, courts have consistently found that it applies in cases involving an insurer's exercise of its subrogation and

reimbursement rights in equity. As Dobbs explains, the "ordinary automobile collision may produce a common fund if the car owner who has been paid by his collision insurer recovers sums from the tortfeasor that include car damages. In such a case the insurer is entitled to share in the recovery . . . but with a deduction for its share of the attorney fee." 1 Dobbs, supra, § 3.10(2), at 394 (emphasis added).

That is exactly this case. Mr. McCutchen was involved in an automobile collision that "produce[d] a common fund" when he "recover[ed] sums from the tortfeasor" that "include[d] . . . damages." As every equitable authority confirms, "[w]here the insured prosecutes the suit against the tortfeasor, thereby incurring legal expenses and court costs, . . . the insurer must at least pay its proportionate share of the expenses." 16 Couch on Insurance, supra, § 61:47, at 131; see also 4 Palmer, supra, § 23.18(d), at 471-72 (any award must "take account of the costs of collecting medical expenses from the tortfeasor, in order to limit the insurer's claim to the insured's net recovery") (emphasis added); 203A Appleman, supra, § 4903.85, at 335 ("It is grossly inequitable to expect an insured, or other claimant, in the process of protecting his own interest, to protect those of the company as well and still pay counsel for his labors out of his own pocket or out of the proceeds of the remaining funds.") (emphasis added).

This is the view of an "overwhelming majority" of decisions, both pre-merger and after: "[A] proportionate share of fees and expenses must be paid by the insurer or may be withheld from its share." Id. at 335. In Faust v. Luke, 364 N.Y.S.2d

344, 347 (N.Y. Civ. Ct. 1975), for example, the court held that "[i]t is manifestly unjust to require the recipient of medical payments, who pays a premium for such coverage, and who is called upon to grant a right of subrogation to the payor, to then, through his or her lawyer, act as a collection agency for the paying carrier in a suit against the tortfeasor." Numerous other cases are in agreement.¹⁰

Courts endorsing the common fund rule all recognize that allowing an insurer—like Petitioner here—to "sit back and become enriched by the fruits of [the insured's] efforts and endeavors" would unjustly enrich the insurer. Id. at 347; see also 4 Palmer, supra, § 23.18(d), at 472 n.56 (an "insurance carrier is unjustly enriched if the insured is forced to bear the cost of recovering medical payments for the carrier's benefit"). Indeed, here, Petitioner made no attempt to participate in the underlying action. Instead, it sat idly by and now seeks to collect the fruits of Mr. McCutchen's and his lawyers' labor. No court of equity would permit this result.¹¹

Note: 10 Sec., e.g., Lee v. State Farm Mut. Auto. Ins. Co., 129 Cal. Rptr. 271, 275 (Cal. Ct. App. 1976); Baier v. State Farm Ins. Co., 361 N.E.2d 1100, 1102 (Ill. 1977); Nat'l Union Fire Ins. Co. v. Grimes, 153 N.W.2d 152, 155-56 (Minn. 1967); State Farm Mut. Auto. Ins. Co. v. Clinton, 518 P.2d 645, 646-47 (Or. 1974); Hospital Service Co. v. Pa. Ins. Co., 227 A.2d 105, 111 (R.I. 1967); Metro. Life Ins. Co. v. Ritz, 422 P.2d 780, 783 (Wash. 1967).

¹¹ Those "few decisions in which attorney's fees have been denied," 203A Appleman, supra, § 4903.85, at 339, arose under well-defined exceptions, not applicable here. See, e.g., Cary v. Phocnix Ins. Co., 78 A. 426 (Sup. Ct. Err. 1910) (fraud): Braun, 124 A. 691 (insurer brought purely legal claim to enforce plan (Footnote continued)

3. The common-fund rule is applicable regardless of whether the subrogation claim is based on an express agreement. The doctrine applies to any case "in which the work of the attorney has produced a fund . . . and in which the benefits are accepted by others." 1 Dobbs, supra, § 3.10(2), at 394. Permitting an insurer to defeat this equitable rule of limitation through contract "would allow the plan to free ride on the efforts of the plan participant's attorney, contrary to the equitable concept of 'common fund' that governs the allocation of attorney's fees" in this type of case. Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Wells, 213 F.3d 398, 402 (7th Cir. 2000).

Wells went on to illustrate the unfairness that would result if an insurer could defeat the commonfund doctrine by disclaiming it in an insurance contract:

Suppose [the insured] had obtained a settlement of \$12,000 of which her lawyer got \$4,000 pursuant to a standard contingent-fee contract, leaving her with \$8,000. Since the settlement would exceed \$10,982.61 [the amount paid by the insurer], the plan under its theory would be entitled to that entire amount, leaving her worse off by \$2,982.61 than she would have

terms); Bradford v. Am. Mut. Liab. Ins. Co., 245 A.2d 478 (Pa. Super. Ct. 1968) (no claim had been made under an insurer's medical payment provision so that no subrogation arose); Travelers Ins. Co. v. Williams, 541 S.W.2d 2d 587 (Tenn. 1976) (insurer notified insured that it would handle the matter personally).

been had she not sued. This would be true even if she had sought no medical benefits, or any other benefits available under the plan, in that suit—it might have been a suit purely for damage to her car.

Id. at 402.

That scenario is not just a hypothetical—it is this case. The Plan's rule leaves Mr. McCutchen "worse off" than if he had not sought to recover for his injuries. Id. "This prospect," as the Wells court observed, "might well deter a suit likely to result in a judgment or settlement not much larger than the benefits available under the plan," and would "produce undercompensation for harms that were unrelated to the type of harm to which the benefits pertain." Id.

4. Petitioner's assertion that its claim takes precedence over the lawyer's claim for attorney's fees is mistaken for another reason. The common fund charge attaches not only to all portions of the fund, no matter who claims a right to them, but also attaches before any other party can assert its right to the fund. See generally Winslow v. Harold G. Ferguson Corp., 153 P.2d 714, 719 (Cal. 1944) ("[C]ounsel fees are customarily made senior to other claims against the fund."); Puett v. Beard, 86 Ind. 172, 174 (1882) ("It is generally agreed . . . that a solicitor has a lien for his costs upon a fund recovered by his aid, paramount to that of persons interested in the fund, or those claiming as their creditors."); see also John P. Dawson, Lawyers and Involuntary Clients: Attorney Fees From Funds, 87 Harv. L. Rev. 1597, 1606-07 (1974) (explaining that the common fund charge on a fund "is a first charge on the fund and must be satisfied before any distribution occurs").

Beyond this, the common fund rule operates to confer a separate equitable lien upon the attorney, implied to prevent unjust enrichment, which allows the attorney himself to come into a court of equity seeking enforcement. See Pettus, 113 U.S. at 127. In Pettus, this Court explained that the common fund rule permitted a court in equity to "declar[e] a lien upon the property in question to secure such compensation as [the attorneys] were entitled," because "an attorney at law or solicitor in chancery has a lien upon a judgment or decree obtained . . . to the extent to which he is entitled to recover, viz., reasonable compensation for the services rendered." Id.; see Kuhn v. Colorado, 924 P.2d 1053, 1058 (Colo. 1996) (noting that this Court "has consistently recognized a substantive right held by the attorney who participates in litigation that creates a common fund to be reasonably compensated out of that fund").12

¹² The United States agrees that attorney's fees should be apportioned between Mr. McCutchen and U.S. Airways under the common fund rule, and that apportionment should be subject to a reasonableness determination. Gov't Br. 26, 27 n.10 (citing *Pettus*, 113 U.S. at 128). The Third Circuit also concluded that an inquiry into the reasonableness of attorney's fees was appropriate, and properly remanded for that purpose. Pet. App. 17a. And courts are more than competent to handle reasonableness determinations. See, e.g., Mathews v. Bankers Life & Cas. Co., 690 F.Supp. 984, 988-89 (M.D. Ala. 1988).

Thus, an attorney can assert this lien irrespective of any other liens already existing or that come into existence when the fund is created, see, e.g., Wash. Gas Light Co. v. Baker, 195 F.2d 29, 33-34 (D.C. Cir. 1951); Krause v. State Farm Mut. Auto. Ins. Co., 169 N.W.2d 601, 605-06 (Neb. 1969), and the attorney's lien may not be defeated by any contractual provision disclaiming such a lien between client and plan, so long as the fund was created through the attorney's effort and for the benefit of multiple parties. See Baier, 361 N.E.2d at 1102.

In short, Petitioner's understanding that, "as best as [it] can tell," courts sitting in equity have "never done what the Third Circuit did here"—limit Petitioner's subrogation-based claim by applying the principles of unjust enrichment—gets it exactly wrong. Pet. Br. 34. What the Third Circuit did here was precisely what courts have done for centuries when resolving purely equitable claims brought by insurers to obtain subrogation.

II. Petitioner's Attempt to Avoid Subrogation Principles Should be Rejected.

Petitioner tries to avoid subrogation principles entirely, arguing that because this case involves an equitable vehicle called "lien by agreement," its subrogation agreement must be enforced as written.

Petitioner advances two arguments justifying its claim: first, that *Sereboff* itself supposedly wiped subrogation principles off the table; and, second, that equitable-lien-by-agreement cases from outside the

subrogation setting dictate that the relief must be based entirely on the agreement. Neither argument withstands scrutiny.

A. Sereboff Did Not Foreclose Application of Principles of Subrogation.

Petitioner misreads Sereboff as foreclosing the application of centuries-old equitable principles when determining the value of a reimbursement claim. Sereboff solely involved the question of whether the plan there had asserted a claim that was cognizable in equity. It did not involve the question of what relief a plan was entitled to receive on proof of that claim, because the Sereboffs failed to "raise[] this distinct assertion below." 547 U.S. at 368 n.2.

The Sereboffs argued that the plan's claim was not cognizable in equity, because the tracing requirements that served as a necessary condition for "freestanding" action for equitable subrogation, were not met. Id. at 368. This Court explained that the Sereboffs were missing the point, because there are different vehicles by which a claimant can open equity's doors, and the plan's reimbursement claim was "indistinguishable" from a lien by agreement—which, although different from a "freestanding" subrogation claim—was nonetheless a claim that equity typically recognized. Id.

There was no suggestion by either the Court or the plan in Sereboff that the relief available under a lien by agreement could contravene the traditional limits that equity imposed on subrogation and reimbursement claims. Indeed, the plan in Sereboff

actively embraced the foregoing principles, taking pains to explain that its "claim for reimbursement. unlike a breach-of-contract claim, limits recovery to the amount received for the particular loss that the already has indemnified." Brief insurer Respondent at 14-15, Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356 (2006) (No. 05-260). Citing Palmer, the plan explained further that "an insurer's subrogation-based rights are driven fundamentally equitable concern to prevent reverse unjust enrichment, rather than to make the insurer whole through breach-of-contract damages." Id. at 15.

Now, just six years after this Court agreed with the plan there and allowed it to bring its claim under § 502(a)(3), Petitioner vehemently rejects the way the plan characterized its claim in Sereboff and reads this Court's ruling as authority for categorically departing from equity's limits on reimbursement. This "have-my-cake-and-eat-it-too" approach is not, as Petitioner claims, mandated by Sereboff. Sereboff was a limited decision about the different species of equitable vehicles that could win reimbursement relief, not an opinion expanding beyond equitable recognition the relief available in reimbursement cases.

As explained above, regardless of which vehicle was used to pursue relief in equity, the rules limiting the availability of relief were the same: an unjust enrichment-based cap on the amount of an insurer's recovery and a requirement to apply a common-fund deduction. It bears reiterating Palmer's teaching on this exact point: The principle of unjust enrichment

applies to a reimbursement lien claim based on an express subrogation clause. 4 Palmer, supra, § 23.18(d), at 473-74.

Under the Plan's contrary approach, these equitable limitations have no application. The Plan insists that, so long as an insurer's subrogation provision meets the initial "criteria" identified in Sereboff—the provision "identifies a particular fund distinct from [a beneficiary's] general assets" and a "particular share of that fund to which [the Plan] was entitled"—that "should be the end of the matter." Pet. Br. 22, 31. After that, a court sitting in equity must award the Plan whatever that provision says it can get.

This cannot be right. Under Petitioner's approach:

1. Fiduciaries could enforce plan language conditioning the payment of insured medical expenses on acceptance of a lien against the entirety of any future tort settlement with (or judgment against) a third party whose conduct generated the need for medical treatment. Such would be true even if the value of the settlement or judgment were five, ten, or even one-hundred times the value of medical expenses advanced.¹³

¹³ Such a lien would be unheard of today; however, it is not fanciful. Indeed, it is a proposal championed by a notable economist and a current Harvard Law School professor. Kenneth S. Reinker and David Rosenberg, Unlimited Subrogation: Improving Medical Malpractice Liability by Allowing Insurers to Take Charge, 29 J. Legal Stud. S261, S262 (2007) ("[W]e advocate (Footnote continued)

- 2. Fiduciaries could condition the payment of insured medical expenses on acceptance of a lien against property entirely unrelated to the sickness or accident triggering the medical payment (for example, "100 percent of any future inheritance received by the insured").
- 3. Perhaps most troubling, fiduciaries could obtain recoupment of overpayments (often already spent, in good faith, by their recipients on basic life needs) through enforcement of an equitable lien by agreement even if the overpayment was based on a fiduciary's breach of some obligation. As Petitioner and its amici correctly note, see Blue Cross Blue Shield Br. 12: Chamber of Commerce Br. 16. § 502(a)(3) is the provision that permits fiduciaries to recoupment of overpayments made participants and/or beneficiaries. Under the status quo, claims for recoupment cannot succeed when the need for overpayment is caused by a breach of fiduciary duty. Adams v. Brink's Co., 261 Fed. App'x 583. 596-97 (4th Cir. 2008) (no overpayment restitution where plan breaches its fiduciary duty). If Petitioner's position is accepted, that would ostensibly change.

These hypotheticals may seem far-fetched, but they are all perfectly consistent with Petitioner's theory. If, as Petitioner says, an "equitable lien by

allowing insurers to subrogate the full potential medical malpractice claims of their insureds without regard to how much the insurer may recover by way of subrogation or how much it pays or promises the insured.").

agreement"—any lien that "identifies a particular fund" and a "particular share of that fund to which [the plan is] entitled"—must be enforced as written in any case absent a showing of fraud, usury, or mistake, why would Plans stop with merely requesting 100 percent reimbursement out of third party recoveries? By decoupling its remedy from the traditional subrogation-based limits, Petitioner's approach has no logical stopping point. It defies reason to think that Congress intended such a result when it limited plan fiduciaries to seeking "appropriate equitable relief" under § 502(a)(3).

B. Equitable Lien by Agreement Cases Outside the Subrogation Context Shed No Light on How These Claims Would Have Been Limited Within the Subrogation Context.

Petitioner's second conceptual move is to pretend that this case has nothing to do with subrogation. Of the twenty-two equitable lien by agreement cases Petitioner cites in its brief, not a single one arises within the subrogation setting or is based upon a subrogation agreement. Petitioner's entire view of this case requires convincing this Court to turn a blind eye to this body of equity. That approach cannot be correct.

1. To begin, Petitioner's argument rests on a central confusion between the equitable rules describing the *creation* of an equitable right and those that governed the *enforcement* of that right. As Dobbs explains, rules governing the *creation* of an equitable right, including equitable liens, are wholly distinct from rules that govern a court's *enforcement*

of that right. The first question is "whether the plaintiff has a right at all" cognizable in equity, which for equitable liens is answered by looking to an agreement's terms, as this Court did in Sereboff and Barnes v. Alexander, 232 U.S. 117 (1913). 1 Dobbs, supra, § 4.1(1), at 552; see also 51 Am. Jur. 2d Liens § 39 (2012) ("An equitable lien may be created by an express contract . . . , or it may arise by implication from the relations and dealings of the parties whose interests are involved."); 53 C.J.S. Liens § 18 (2012) ("Contract as basis").

However, when it comes to enforcing equitable liens, the rules did not vary with the method of creation. As the Government explained in *Knudson*, an "equitable lien is another equitable remedy intended to prevent unjust enrichment and may arise out of an express agreement or may be judicially implied." Brief of United States as *Amicus Curiae* Supporting Petitioners at 24, *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002) (99-1786); see also Cheff v. Haan, 257 N.W. 894, 896 (Mich. 1934); Kelly v. Kelly, 19 N.W. 580, 588 (Mich. 1884); 51 Am. Jur. 2d Liens § 82; 53 C.J.S. Liens § 49.14

¹⁴ If the relief available to an insurer is governed by exactly the same equitable rules whether or not the plan includes a subrogation clause, one might ask why an insurer would ever include an express subrogation provision in its policy. First, before the 1930s, courts prohibited medical insurers from pursuing subrogation at all unless the insurer included an express clause. 10A Couch on Insurance 3d § 144:6 (L. Ross & T. Segalla eds., 3d ed. 2011). See also Amer. Indem. Co. v. N.Y. Fire & Marine Underwriters, Inc., 196 So. 2d 592 (La. App. (Footnote continued)

2. That cases in equity awarded a measure of relief that looked like contractual damages does not change this fact. In many cases, the "appropriate" measure of relief consistent with the defendant's unjust enrichment was coextensive with the relief specified by the terms of the agreement, and the plaintiff's loss. See 1 Dobbs, supra, § 4.1, at 227-28.

Indeed, in most lien-by-agreement cases, there is no reason why enforcing the terms of the agreement would even implicate, let alone offend, equitable principles. For instance, in Barnes, once the right to an equitable lien was established, this Court granted Alexander and Street a measure of relief under their equitable lien consistent with the agreement's terms-"one-third" of any contingent fee recovered. 232 U.S. at 120-21. Petitioner sees this outcome as proof that equitable liens by agreement must be enforced according to their terms, and not "generalized concept on a of uniust enrichment." Pet. Br. 36. But the result in Barnes was consistent with principle the of unjust enrichment because the agreement created measure of recovery that would always correspond with the defendant's unjust gain. The lien in Barnes was tied to a percentage, which can slide according to the relative size of the fund. Thus, there was no question of measurement, and no possibility that the

^{1967).} Moreover, as explained above (at n.8), in some cases insurers could pursue *legal* relief based on a breach of contract claim, but, by definition, only where the policy contained an express subrogation clause. Finally, for ERISA-governed plans in particular, an express subrogation clause is required if the Plan is to have *any* right to subrogation. See infra at Part II.C.

lien could exhaust the entire fund or exceed the amount of the fund constituting the defendant's unjust gain.¹⁵

Equally unpersuasive is Petitioner's claim that cases involving the equitable remedy "specific performance" prove that equity courts must enforce contracts as written. See id. at 29 (citing Good v. Jarrard, 76 S.E. 698, 702 (S.C. 1912)). Contrary to Petitioner's insistence, these cases demonstrate that courts often refused to award a measure of relief consistent with the terms of an agreement where doing so would conflict with the principle of unjust enrichment.

As this Court put it: "Specific performance is not of absolute right. It rests entirely in judicial discretion, exercised, it is true, according to the settled principles of equity, and not arbitrarily or capriciously, yet always with reference to the facts of the particular case." Hennessy v. Woolworth, 128 U.S. 438, 442 (1888); see also Willard v. Tayloe, 75 U.S. 557, 566 (1870) (explaining the "settled principle that a specific performance of a contract of sale is not a matter of course," but rather within the "discretion of the court upon a view of all the circumstances").

¹⁵ Petitioner is wrong to suggest that the Court's "reject[ion]" of Mrs. Barnes' attempt to limit the lien is somehow controlling here. See Pet. Br. 35. There was no question that the lien attached only to the whole of Mr. Barnes' share, see Barnes, 232 U.S. at 123, and not to his law partner's. If anything, this fact illustrates why allowing the Plan to impose a lien over portions of Mr. McCutchen's fund not in compensation for the losses it paid would have been improper in equity.

This case, of course, does not involve specific performance. Petitioner's claim that agreements abolish equitable limits, however, does not—either specifically with respect to reimbursement claims or generally with respect to how agreements were treated in equity—hold water.

Nor are Petitioner's multiple "mortgage lien" cases any more persuasive. See Pet. Br. 34-35. Those cases just illustrate what the above authorities say: There are specific rules (that often look a lot like contract rules) governing the creation of equitable liens based on agreement, but those rules do not necessarily control an equity court's fashioning of relief pursuant to the lien. See, e.g., Foster Lumber Co. v. Harlan Cntv. Bank. 80 P. 49, 50-51 (Kan. 1905) (applying maxim that equity "treats that as done which a party, under his agreement, ought to have done" to establish the lien, but enforcing it because the defendant made "[n]o effort . . . to exclude any of the items utilized in computing the amount of the lien"); S. Ice & Coal Co. v. Alley, 154 S.W. 536, 539 (Tenn. 1913) (explaining that the maxim "equity looks upon things agreed to be done as actually performed" applies to the "creat[ion] of a mortgage in equity, or a specific equitable lien on the property") (alteration omitted).

These mor*gage lien cases are unpersuasive for another reason: They are frequently "two party" cases in which the defendant caused the plaintiff's loss. See, e.g., Southern Ice, 154 S.W. at 537 (ice company sought to enforce lien against defendant after he refused to honor property agreement); Adkinson & Bacot Co. v. Vornado, 47 So. 113, 113

(Miss. 1908) (husband and wife executed mortgage and then refused to transfer property under agreement). As these cases demonstrate, the unjust enrichment inquiry is virtually always straightforward: A party who has caused a loss to another (and as a result has unjustly gained) should be forced to disgorge that gain.

In this case, however, like in all subrogation cases, because the party causing the loss is often an unrelated third party, the rules that equity courts apply are not the same. See 4 Palmer, supra, § 23.1, at 341-42 (including discussion of subrogation-based claims in chapter on "Three-Party Problems: Two Parties Separately Liable to a Third"). Where the wrongdoer who causes the loss is a third party. determining who has been unjustly enriched, and by how much, requires a different set of rules for adjusting the rights and relief among the parties. See id. § 23.1, at 342-45. Sometimes, the measure of relief will look similar to two-party cases, for instance where the insured recovers an amount from the tortfeasor that includes complete compensation for the losses paid by the insured. See, e.g., Manley v. Montgomery Bus Co., 82 Pa. Super. Ct. 530, 533-34 (1923). But this does not always happen, as this case illustrates. Lumping this case in with those twoparty cases fails to account for this difference, and ignores the jurisprudence requiring a different approach.

Petitioner's error is to equate its cases with a black-letter rule of exclusion that prioritizes the terms of an agreement over all other equitable principles that might apply to the subject of the agreement or the relief a party could obtain. Certainly a lien's terms should be enforced to the extent they do not conflict with other equitable principles. But where absolute enforcement of a lien's terms would conflict with subrogation principles, cases not involving subrogation-based rights say precisely nothing about whether those principles should be set aside. And the treatises say the opposite: Regardless of whether the asserted equitable right arises from "agreement" or not, the equitable limits apply.

3. The real question, and the relevant one in this case, is what happens when the unjust enrichment measurement diverges from a contractual damages measure? Petitioner views liens by agreement as magic documents that shrink equity to the four corners of an agreement, with no recourse to supervening equitable principles applicable to the circumstances or subject of the agreement. This convenient and self-serving approach to equity jurisprudence is contradicted not only by the equitable authorities, as explained above, but also by Petitioner's own cases.

Consider: Petitioner relies heavily on Manufacturers' Finance Co. v. McKey, 294 U.S. 442 (1935), for the proposition that "equity cannot change contractual terms in the absence of fraud or the like." Pet. Cert. Reply at 7; Pet. Br. 24. What Petitioner neglects to mention is that McKey went on to hold that when a party comes into a court of equity seeking exclusively equitable relief, he will "be required to submit to the operation of a rule which always applies in such cases, and do equity in order

to get equity." 294 U.S. at 449. As this Court explained, unlike the enforcement of a legal right in equity—where the "terms of the legal obligation" control even if "the court thinks that these terms are harsh or oppressive or unreasonable"—when a party seeks to enforce a purely equitable right, he must take his relief subject to those limiting principles (or defenses) of equity that would have typically applied to his claim. *Id.* at 448-49.

Petitioner cannot deny that it is presently seeking equitable relief; were that not so, it would be forbidden from proceeding under § 502(a)(3). Against that fact, Petitioner simply cannot avoid application of equitable principles with regard to the enforcement of its equitable lien.

C. Petitioner's Statutory Argument Fails.

Petitioner also argues that, because § 502(a)(?) allows for appropriate equitable relief "to enforce[] the terms of the plan," a court must enforce plan language as written. This argument fails for several reasons.

1. Petitioner's argument misconstrues the point of Congress' language. The reference to the "terms of the plan" was intended to restrict the types of claims that a party may assert under § 502(a)(3) to only those arising out of the plan itself. See Mertens, 508 U.S. at 254 (Section 502(a)(3) "does not, after all, authorize 'appropriate equitable relief at large, but only 'appropriate equitable relief for the purpose of 'redressing any violations or enforcing any provisions' of ERISA or an ERISA plan.") (alterations omitted; emphasis in original). Those claims,

Congress stated, must arise out of violations of ERISA itself or the terms of the plan—and be levied against *only* those subject to ERISA's duties or a party to the plan—but may not include generalized freestanding equitable claims for relief against anybody within shooting distance.

In the context of this case, that means Petitioner, or any plan fiduciary, could not maintain freestanding claim for reimbursement, where its plan no express subrogation clause. contained this limitation although serves important an gatekeeping function. it does not override § 502(a)(3)'s limitation that a party may only obtain that relief which was appropriate in equity. See, e.g., Peacock v. Thomas, 516 U.S. 349, 353 (1996) (holding that because "alleged wrongdoing 'did not occur with respect to the administration or operation of the plan'," the complaint "failed to allege a claim under § 502(a)(3) for equitable relief"); Mertens, 508 U.S. at 253 (noting that a claim against an actuary would likely be improper because his actions were not alleged to have violated any terms of the plan or of ERISA itself, and therefore did not fall within the scope of § 502(a)(3)).16

¹⁶ See also Cataldo v. U.S. Steel Corp., 676 F.3d 542, 556 (6th Cir. 2012) (dismissing claim for various forms of "equitable relief" under § 502(a)(3) where plaintiffs failed to allege a violation of ERISA); Fotta v. Tr. of United Mine Workers of Am., 319 F.3d 612, 617 (3d Cir. 2003) (holding that plan beneficiary can sue under § 502(a)(3) for interest on delayed benefits "only if those benefits were wrongfully withheld or wrongfully delayed, that is, only if they were withheld or delayed in violation of ERISA or an ERISA plan"); Colleen Medill, Resolving the Judi-(Footnote continued)

2. Petitioner's interpretation of § 502(a)(3)—that it contemplates the strict enforcement of plan terms-is further undermined by the fact that Congress included just such a contractually based enforcement provision in the statutory provision immediately preceding § 502(a)(3). participants authorizes 502(a)(1)(B), beneficiaries to enforce their rights "under the terms of a plan." 29 U.S.C. § 1132(a)(1)(B). Tellingly absent from this provision is any reference to plan fiduciaries; to the contrary, Congress specified that a civil action brought to "enforce . . . rights under the terms of the plan" may only be brought by plan "participant[s] or beneficiar[ies]." Id. Yet that is precisely the relief being sought by Petitioner here.

Had Congress intended to allow a plan to secure precisely the type of relief authorized under § 502(a)(1)(B), surely it would have said so. But Congress said no such thing—an omission that speaks volumes. See Knudson, 534 U.S. at 217-18; Russell, 473 U.S. at 146 ("The assumption of inadvertent omission is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated and interdependent remedial scheme . . . ").

cial Paradox of "Equitable" Relief Under ERISA Section 502(a)(3), 39 J. Marshall L. Rev. 827, 943 (2006) (noting that "[t]he language of Section 502(a)(3) is clear that the nature of the claim must be limited to a violation of the statutory provision of title I of ERISA or a violation of plan terms").

Notably, Petitioner's brief barely mentions § 502(a)(1)(B), other than to state that it provides participants and beneficiaries "alike" mechanisms to enforce the terms if the plan. Pet. Br. 2, 5-6. Of course, (a)(1)(B) and (a)(3) are not "alike" in their enforcement mechanisms. Petitioner does address this difference, pretending instead that § 502(a)(1)(B) has no bearing on § 502(a)(3). As this Court has recognized, however, ERISA's carefully crafted and detailed enforcement scheme "provide[s] strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." Russell, 473 U.S. at 146 (emphasis in original).

Applying a categorical rule of "enforc[ing] the terms of the plan" would up-end this enforcement scheme by permitting Plans to perform an end-run around the limitations imposed by § 502(a)(3). That move should not be sanctioned by this Court. Whatever else, a request to "enforce the terms of the plan" will be "inadequate to overcome the words of [ERISA's] text regarding the specific issue under consideration" where doing so would render those words "devoid of reason and effect." Knudson, 534 U.S. at 220 (citation omitted; emphasis in original). 17

¹⁷ The United States makes much of the term "appropriate" in § 502(a)(3). Gov't Br. at 13-14. Thus, the Government argues that "the word 'appropriate' . . . direct[s] the court to choose a particular remedy that is well suited to the circumstances." *Id.* at 14. Respondents agree with this uncontroversial proposition, as far as it goes. Where Respondents and the Government diverge is over what *relief* is "well suited to the circumstances," given the "particular remedy."

- III. Petitioner's Claim that Imposing Limits on Reimbursements Would Harm ERISA Plans and Beneficiaries Is Unsupported and Untrue.
- 1. Petitioner and its amici (most of which are themselves ERISA plans) strenuously assert that placing any equitable limits on reimbursement would seriously threaten the financial viability of self-funded ERISA plans and limit employees' access to affordable, quality health care. However, the plans have not offered a scintilla of actual evidence that their apocalyptic vision of life under the Third Circuit's approach will come to pass. This is telling, given that it is the plans themselves who are in the position to provide the data proving their point. 18

At no time during this case—or during any other case of which Respondents are aware—has any plan ever provided any actual evidence that subrogation recoveries factor into rate-setting, or that, if these recoveries are limited in the modest ways equity requires, insurers would be forced to abandon ship or slash coverage. Petitioner had ample opportunity to present evidence about, for example, the size of its reimbursement revenue or the percentage of claims in which reimbursement is sought, but it chose not to. The same is true of Petitioner's amici—who, after all, are not limited by the evidence in the record. Not one amici brief sheds any factual light on these

¹⁶ ERISA plans, unlike insurance providers subject to state law, are not required to disclose information regarding rate-setting and other internal practices, so this information is hard to come by—unless, of course, the plans themselves choose to disclose it, which they have not.

questions; instead, the briefs rely exclusively on unsupported statements in case law and hypotheticals in law review notes. This alone is reason enough to disregard their gloomy predictions.¹⁹

2. Meanwhile, what evidence is publicly available suggests that the economic concerns raised by the plans are grossly exaggerated. For starters, a number of courts and scholars have concluded that plans do not take reimbursement proceeds into account when setting premium rates.²⁰

¹⁹ For example, the plans rely on Zurich American Insurance Co. v. O'Hara, 604 F.3d 1232, 1238 (11th Cir. 2010), in which the court relied on Wal-Mart Stores, Inc. Associates' Health & Welfare Plan v. Shank, 500 F.3d 838 (8th Cir. 2007), which, in turn, relied on Harris v. Harvard Pilgrim Health Care, Inc., 208 F.3d 274, 280-81 (1st Cir. 2000), which relied on Sunbeam-Oster Co. Group Benefits Plan for Salaried & Non-Bargaining Hourly Employees v. Whitehurst, 102 F.3d 1368, 1376 n.23 (5th Cir. 1996), which relied on Cutting v. Jerome Foods, Inc., 993 F.2d 1293, 1298 (7th Cir. 1993), which cited no authority. See also Jeffrey A. Greenblatt, Insurance and Subrogation: When the Pie Isn't Big Enough, Who Eats Last?, 64 U. Chi. L. Rev. 1337, 1354-55 (1997) (posing a hypothetical).

²⁰ See, e.g., Cooper v. Argonaut Ins. Co., 556 P.2d 525, 527 (Alaska 1976); Allstate Ins. Co. v. Druke, 576 P.2d 489, 492 (Ariz. 1978) (in banc); DeCespedes, 193 So.2d at 227-28; Travelers Indem. Co. v. Chumbley, 394 S.W.2d 418, 425 (Mo. Ct. App. 1965); Maxwell v. Allstate Ins. Co., 728 P.2d 812, 815 (Nev. 1986); Rimes v. State Farm Mut. Auto. Ins. Co., 316 N.W.2d 348, 355 (Wis. 1982); John F. Dobbyn, Insurance Law in a Nutshell 284 (3d ed. 1996); Edwin W. Patterson, Essentials of Insurance Law § 33 (2d ed. 1957); 2 G. Richards, The Law of Insurance § 183 (5th ed. 1952); Andrew H. Koslow, "Appropriate Equitable Relief" in Wal-Mart v. Shank: Justice for Whom?, 12 Quinnipiac Health L.J. 277, 279 (2009). See also Johnny C. (Footnote continued)

The conclusion that reimbursement rates have close to zero impact on coverage and premium rates is supported by the fact that, for at least one of the amici plans, reimbursement recovery is miniscule in comparison to the total value of the claims the plan pays out. Amicus Central States, Southeast and Southwest Areas Health and Welfare Fund ("Central States"), a multiemployer self-funded ERISA plan, points out in its brief (at 3) that that it has an average annual reimbursement recovery of \$5.7 million, while paying out over \$1 billion in benefits each year, making its reimbursement rate approximately one half of one percent.²¹

There is no reason to doubt that this is par for the course. The amount of reimbursement is likely so small relative to total pay-outs because reimbursement is inherently unpredictable only narrow circumstances: available in beneficiary's injury must have been caused by a third party; the injuries must be severe enough for the beneficiary to bring a lawsuit; and the beneficiary must have actually recovered.

Parker, The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation, 70 Mo. L. Rev. 723, 736-37 (2005); Roger M. Baron, Subrogation: A Pandora's Box Awaiting Disclosure, 41 S.D. L. Rev. 237, 243-45 (1996).

²¹ See Central States, Southeast and Southwest Areas Health and Welfare Fund Comments on the Proposed and Interim Rules Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act 2 (Sept. 24, 2010), available at http://www.dol.gov/ebsa/pdf/1210-AB45-0087.pdf.

Assuming a one-half-of-one-percent rate of reimbursement is more or less typical, it is hard to imagine that the rate of premiums (or the level of plan benefits) would change perceptibly if, in some cases, plans were required by equity to limited reimbursement. Add to this the fact that the overwhelming number of these cases settle, and it seems likely that the financial difference on between the right to 100 premiums percent reimbursement with no deduction for costs and fees and equitably limited reimbursement is relatively small. See Blue Cross Blue Shield Br. 5-6 (explaining that most reimbursement claims are settled); Nat'l Coordinating Comm. Br. 23 (same).

If the plans were correct that any limitations on full reimbursement will inevitably increase premiums, one would expect that to be true where reimbursement is prohibited or limited. But all evidence is to the contrary. Plans that are not self-funded are already subject to state-law prohibitions or limitations on reimbursement, but in 2012, premiums for those plans are actually lower than in self-funded ERISA plans. Kaiser Family Found. & Health Research & Educ. Trust, Employer Health Benefits: 2012 Annual Survey 20 (2012), available at http://ehbs.kff.org/pdf/2012/8345.pdf.²² Further,

²² Over the last 14 years, for large employers, self-funded plans had lower average premiums in half the years, and insured plans had lower premiums in the other half. Kaiser Family Found., Employer Health Benefits, at 28. In all years, the premiums were similar, indicating that the extent of reimbursement available has no or virtually no impact on premium rates. *Id.* at 14, 28.

outside of the self-funded ERISA plan context, states with the most significant restrictions on reimbursement—where it is prohibited or subject to the make-whole doctrine—do not appear to have higher healthcare premiums than states where insurers may contract for unrestricted reimbursement.²³

Nor have insurers left the marketplace in states where reimbursement is categorically prohibited by statute—Kansas, Kan. Admin. Regs. § 40-1-20; Virginia, Va. Code Ann. § 38.2-3405; and, in the car accident context, Pennsylvania, 75 Pa. Cons. Stat. § 1720—or where insurers cannot seek reimbursement until the beneficiary is made whole, for example, Georgia, Ga. Code Ann. § 33-24-56.1; Nebraska, Blue Cross Blue Shield of Neb., Inc. v. Dailey, 687 N.W.2d 689, 699-700 (Neb. 2004); and Wisconsin, Rimes, 316 N.W.2d at 350.

²³ To cite just a few examples, the average premium in 2010 in Virginia, where reimbursement is prohibited, was \$240, while the average premium in neighboring West Virginia, where a plan can contract for full reimbursement, was \$333. Henry J. Kaiser Family Found., Average Per Person Monthly Individual Premiums in the Market. http://www.statehealthfacts.org/comparemaptable.jsp?ind=976 &cat=5 (last visited Oct. 15, 2012); Va. Code Ann. § 38.2-3405 (Virginia anti-subrogation statute); Bush v. Richardson, 484 S.E.2d 490, 494 (W. Va. 1997) (in West Virginia, make-whole rule may be overridden by express plan terms to that effect). So too between Wisconsin (made-whole applies, premiums average \$201) and Minnesota (contract rules govern, premiums average \$250). Rimes, 316 N.W.2d at 350; Medica, Inc. v. Atl. Mut. Ins. Co., 566 N.W.2d 74, 77 (Minn. 1997).

Nor is there any evidence that the lower court's would dramatically increase approach administrative costs by requiring "mini-trials" over each claimant's share of recovery. The reality, which some of amici recognize, is that the majority of reimbursement claims are settled. See Blue Cross Blue Shield Br. 5-6 (explaining that plans usually resolve reimbursement claims to the satisfaction of beneficiary rather than seeking reimbursement); Nat'l Coordinating Comm. Br. 23 Further. other federally regulated reimbursement schemes are subject to equitable limitations, and these regimes have not been crippled by a litigation explosion. For example, Medicaid claims for reimbursement are subject to double recovery principles, Ark. Dep't of Health & Human Servs. v. Ahlborn, 547 U.S. 268, 274-75 (2006), and Medicare claims are subject to common fund, 42 C.F.R. § 411.37. And, as the United States explains in its brief, reimbursement under the Longshore and Harbor Workers' Compensation Act and the Federal Employees Health Benefits Act is subject to reductions for attorney's fees and costs, Gov't Br. 30-32; see 33 U.S.C. § 933(f) (Longshore Act), yet there is no indication that extensive resources are being consumed in reimbursementrelated litigation.

If anything, there is every reason to believe that Petitioner's full-reimbursement approach would increase litigation costs by making it less likely that tort claimants would be willing to settle cases. As this Court has recognized, there is a strong public policy interest in the expeditious resolution of lawsuits through settlement. See, e.g., McDermott,

Inc. v. AmClyde, 511 U.S. 202, 215 (1994). Under Petitioner's proposed scheme, an injury victim who acts reasonably to settle his tort claim would automatically make himself liable for repayment of the total amount of medical expenses irrespective of the actual amount of the settlement that is allocable to those expenses. Under this regime, many injury victims would have virtually no incentive to settle their claims. Instead, in many cases it would make better economic sense to "roll the dice" in hopes of obtaining a larger recovery through trial, thereby burdening the courts with cases that otherwise would have settled, and driving up litigation costs for both the beneficiary and the plan. Cf. Ahlborn, 547 288 (explaining that 100 reimbursement would deter settlement); Bradley v. Sebelius, 621 F.3d 1330, 1339 (11th Cir. 2010) (explaining that a rule of absolute priority would "compel | plaintiffs to force their tort claims to trial, [thereby] burdening the court system," and creating "a financial disincentive" to settlement).

That the approach espoused by Petitioner would deter settlement is a view shared by both sides of the bar. In the same Medicare context as Bradley, the insurance industry and defense bar have argued that insurer to obtain 100 percent allowing an reimbursement would defeat the "strong public interest in the expeditious resolution of lawsuits through settlement," thereby driving up the costs of litigation for all parties and burdening the courts. Id. at 1339; Brief of DRI-The Voice of the Defense Bar as Amicus Curiae Supporting Petitioner at 11-18, Hadden v. United States, No. 11-1197, (U.S. Oct. 1, 2012); Brief of Property Casualty Insurers of America, et al. at 6-8, Hadden, No. 11-1197, (U.S. Oct. 1, 2012). See also Mark Galanter, The Hundred-Year Decline of Trials and the Thirty Years War, 57 Stan. L. Rev. 1255, 1272-74 (2005).

Regardless, if plans are really concerned that anything but full reimbursement would dramatically increase costs and decrease revenues, there is nothing to prevent them from exercising their subrogation rights and suing the third-party tortfeasors directly. To be sure, this would entail some additional expense, but because most reimbursement cases settle, the costs should be within reason. That plans would prefer to freeride on the efforts of the beneficiaries and their lawyers highlights that what the plans are seeking here is a windfall that would have been unavailable to them under traditional equitable principles of unjust enrichment.

3. In short, available evidence suggests that placing some limits on the ability of ERISA insurers to recover full reimbursement in every case, without contributing to costs or fees, will not harm either plans or beneficiaries in any significant respect.

Petitioner's claim to the contrary should be seen for what it is: a smoke screen to disguise the fact that a rule of unlimited reimbursement would make ERISA an outlier among reimbursement schemes. To Respondents' knowledge, no federal statute permits an insurer from obtaining unlimited reimbursement when the insured has recovered against a third party. See 5 U.S.C. § 8132 (Federal Employees' Compensation Act); 33 U.S.C. § 933(f) (Longshore and Harbor Workers' Compensation Act); Ahlborn,

547 U.S. at 274-75 (Medicaid); 42 C.F.R. § 411.37 (Medicare); Gov't Br. 31-32 (Federal Employees Health Benefits Act). Many states, too, place at least some limitations on the availability of this relief. See generally Parker, supra (surveying states). There is no reason to make an exception for ERISA, particularly when Congress has specifically provided that only "appropriate equitable relief" is available under § 502(a)(3).

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

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REPLY BRIEF

Supreme Court of the United States

U.S. AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN,

Petitioner,

V.

JAMES MCCUTCHEN and ROSEN, LOUIK & PERRY, P.C., Respondents.

> On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

REPLY BRIEF FOR PETITIONER

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Supreme Court of the United States

U.S. AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN,

Petitioner,

v.

JAMES MCCUTCHEN and ROSEN, LOUIK & PERRY, P.C., Respondents.

> On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

REPLY BRIEF FOR PETITIONER

INTRODUCTION

Petitioner explained in its opening brief that ERISA reimbursement provisions should be enforced as written for two reasons: ERISA authorizes appropriate equitable relief to "enforce * * * the terms of the plan," 29 U.S.C. § 1132(a)(3), and equity courts treat the equitable lien by agreement as a mechanism to enforce bargains by their terms. Respondents offer no persuasive response. Instead, they put all their chips on a lone assertion: that "[t]his case is about 'subrogation,' " and that as a result Petitioner's claim "must be measured according to the equitable principle of unjust enrichment." Resp. Br. 2, 13.

That assertion is wrong. To begin with, it is foreclosed by Sereboff v. Mid Atlantic Medical Services, Inc., which rejected an identical attempt to treat an ERISA reimbursement claim as subrogation. As the Court explained there, "Mid Atlantic's claim is not considered equitable because it is a subrogation claim. *** Accordingly, the parcel of equitable defenses the Sereboffs claim accompany any [subrogation] action are beside the point." 547 U.S. 356, 368 (2006). So too here.

Respondents' "subrogation" gambit is likewise fore-closed by the treatises. Those treatises explain that reimbursement and subrogation are "different both in their functioning and in their legal effect." 16 L. Russ et al., Couch on Insurance § 226:4 (3d ed. 2011) (Couch). They explain that when a claim "is based upon the subrogation right," "[t]his is not an express lien based on agreement." 1 G. Palmer, The Law of Restitution § 23.18, at 470 (1978) (Palmer). And they make clear that an equitable lien by agreement is "distinguish[ed] *** from the equitable lien imposed by the courts to prevent unjust enrichment." 1 D. Dobbs, Law of Remedies § 4.3(3), at 601 (2d ed. 1993) (Dobbs).

Respondents, in short, have put all their stock in a legal framework that does not apply. They also mischaracterize the record in several significant respects. Respondents assert, for example, that the U.S. Airways Plan was "unilaterally drafted," Resp. Br. 2, but neglect to mention that it was collectively bargained, CA3 Appendix 201. And Respondents assert that they "asked for a 'complete copy of the plan or trust document.'" Resp. Br. 6 & n.1 (quoting J.A. 44-45). But there is no period after "document" in the original, because what Respondents asked for was "a complete copy of the plan or trust document, or summary description." J.A. 44-45 (emphasis added). The summary description is in the record, J.A. 20, and as the Solicitor General notes, "the

parties *** have treated the SPD provisions as accurately reflecting the relevant plan terms." U.S. Br. 3 n.2.1

In the final analysis, Respondents' misdirections do not undermine the approach adopted by most circuits and set forth in the opening brief. As the Solicitor General put it: "Because petitioner's suit under Section 502(a)(3) is one to enforce an equitable lien by agreement, respondent's obligation to petitioner is determined by the plan, not by general unjust enrichment or other principles of equitable restitution." U.S. Br. 14. The decision below should be reversed.

ARGUMENT

- I. SECTION 502(a)(3) AND EQUITABLE-LIEN-BY-AGREEMENT CASES, NOT SUBROGATION PRINCIPLES, SUPPLY THE RULE OF DECISION.
 - A. Section 502(a)(3) And The Equitable-Lien-By-Agreement Doctrine Require Reversal.
- 1. We begin, unlike Respondents, with the statutory text. Section 502(a)(3) authorizes "appropriate equitable relief" to "enforce * * * the terms of the plan." 29 U.S.C. § 1132(a)(3). As this Court has recognized, that provision plainly "provides for equitable remedies to enforce plan terms." Sereboff, 547 U.S. at 363. Under Respondents' approach, however, courts would not "enforce plan terms"; they would rewrite them. That is inconsistent with

Which they do. Respondents now claim the Plan "contains several material differences" from the SPD. Resp. Br. 7 n.1. But they identify no such differences. Moreover, CIGNA Corp. v. Amars, 131 S. Ct. 1866 (2011), was decided while this case was pending below, and Respondents knew about it; they even raised it as supplemental authority for another point. And yet they never argued that the SPD should no longer control.

Section 502(a)(3)'s text. It is equally inconsistent with two fundamental guideposts of ERISA: Plans choose their own terms, and those terms control. Petr. Br. 5-6; U.S. Br. 13.

Respondents offer two responses, neither well-grounded in the text. They first say the statutory "reference to the 'terms of the plan' " merely signals "the types of *claims* that a party may assert under § 502(a)(3)"—namely, those arising from the plan. Resp. Br. 44. Again, however, Respondents omit a key word. Section 502(a)(3) does not merely "reference" the "terms of the plan." It authorizes appropriate equitable relief to "enforce" the terms of the plan.

Respondents next point out that the adjacent Section 502(a)(1) authorizes plan beneficiaries, but not plans themselves, to enforce ERISA plans by a contract action at law. Resp. Br. 46. According to Respondents, the fact that Congress denied plans a remedy at law in Section 502(a)(1) must mean plans cannot turn around and enforce plan terms through Section 502(a)(3).

That argument relies on a fallacy: that enforcement of an agreement's terms is necessarily a remedy at law. It is not. As this Court has explained, Sereboff, 547 U.S. at 365, there exists an equitable remedy—the equitable lien by agreement—designed to make a promisor pay what it agreed to pay. That is not legal relief. Sec 4 S. Symons, Pomeroy's Equity Jurisprudence § 1234, at 695 (5th ed. 1941) (Pomeroy). Moreover, when a plan advances an equitable-lien-by-agreement claim, it must meet the requirements for that relief, including specification of "a particular fund." Sereboff, 547 U.S. at 357. Petitioner's claim accordingly is different from an action at law. There

is no "end-run" around Section 502(a)(3). Resp. Br. 47.

That is all Respondents offer in the way of statutory analysis. And that itself is notable. For Respondents make little attempt to press the theory that drove their argument below: that the word "appropriate" in Section 502(a)(3) authorizes courts to import freewheeling equitable offsets to override plan terms. And they make no attempt to counter the showing, by Petitioner and the United States. that this Court has interpreted "appropriate" to have a more sensible meaning. See Petr. Br. 21 (Court interprets "appropriate" to denote a mode of equitable relief suitable to enforce the plan); U.S. Br. 6 (same); Varity Corp. v. Howe, 516 U.S. 489, 512 (1996) ("appropriate" also signals that Section 502(a)(3) is a "catch-all" and that if a beneficiary can proceed under another remedial provision, he must do so). The Court should reject a reading of "appropriate" so broad that it undercuts Congress's express purposes and overbears the remaining statutory text.

2. Sereboff held that ERISA reimbursement provisions create an equitable lien by agreement. 547 U.S. at 365. Petitioner demonstrated in the opening brief that the raison d'etre of the equitable lien by agreement is to "enforce[]" the terms of the "agreement of the parties." Dobbs § 4.3(3), at 601; Petr. Br. 31-37. That showing suffices to resolve the case, even apart from the statute. And Respondents do nothing to rebut it.

Instead, Respondents launch what amounts to an attack on Sereboff itself. Respondents argue that our reliance on equitable-lien-by-agreement cases is misplaced because they "ha[ve] nothing to do with subrogation." Resp. Br. 37. True; they have nothing

to do with subrogation. That is because Sereboff made clear that ERISA reimbursement provisions should be analyzed as equitable liens by agreement and not as subrogation. 547 U.S. at 365, 368; see also infra at 7-14. Sereboff in turn drew its rule from a case—Barnes v. Alexander, 232 U.S. 117 (1914)—that had nothing to do with subrogation. Respondents' critique of our equitable-lien-by-agreement argument ignores this Court's decisions.²

Respondents next argue that while equitable liens may arise out of agreements, they nonetheless are enforced only to the extent necessary to prevent unjust enrichment. Resp. Br. 37-38. Here Respondents repeat the Third Circuit's mistake: conflating disparate equitable doctrines. An equitable lien for restitution is enforced to prevent unjust enrichment. Petr. Br. 38-39; Dobbs § 4.3(3), at 601. But an equitable lien by agreement is enforced to make a promisor live up to its bargain. Good v. Jarrard, 76 S.E. 698, 702 (S.C. 1912); Petr. Br. 31-35. Courts in equitable-lien-by-agreement cases thus have rejected offsets akin to the one Respondents seek. See Barnes, 232 U.S. at 121-123. And Sereboff made clear that reimbursement provisions like the one

² Respondents mischaracterize certain additional facts. They assert that Petitioner's agent Ingenix ignored their letters, Resp. Br. 7-8, but in fact the parties corresponded throughout summer 2008, J.A. 33; CA3 Appendix 198-200, 205, 213, 216. And they say Ingenix never "provided * * * adequate documentation that it was self-funded," Resp. Br. 7, but in fact Ingenix supplied the relevant document (the Plan's IRS form 5500), CA3 Appendix 201-202. In any event, the District Court rejected any notion that this is not a self-funded plan (Pet. App. 22a), and Respondents did not renew the argument in the Third Circuit.

here amount to equitable liens by agreement—not equitable liens for restitution, a "different species of relief." 547 U.S. at 364-365.3 Remedial conditions associated with one form of relief do not apply to the other.

B. This Case Is About Neither Subrogation Nor Unjust Enrichment.

Respondents spend most of their brief trying to change the subject: They assert that "[t]his case is about subrogation" and that Petitioner's relief "must be measured according to the equitable principle of unjust enrichment," Resp. Br. 2, 13, and they proceed to describe at length the limits some courts apply to subrogation, id. at 13-37. That subrogation premise drives every one of Respondents' arguments about "double recovery." But the premise is wrong; indeed, it is flatly rejected by Sereboff and Respondents' preferred treatises.

1. Sereboff squarely forecloses Respondents' contention that "[t]his case is about subrogation." The plan participants in Sereboff argued that "they would in an equitable subrogation action be able to assert certain equitable defenses," including the "made whole" principle—a principle that, like the double-recovery rule Respondents seek, arises in subrogation. 547 U.S. at 368. This Court rejected that premise:

³ Respondents (at 39-42) contend that "three-party" cases are somehow different from "two-party" ones. But the notion that third parties are relevant is just another manifestation of Respondents' mistaken focus on subrogation. The key fact in equitable-lien-by-agreement cases is the existence of a specified fund, and share thereof, that a promisor agrees to hand over.

Mid Atlantic's claim is not considered equitable because it is a subrogation claim. * * * [It] qualifies as an equitable remedy because it is indistinguishable from an action to enforce an equitable lien established by agreement. * * * Mid Atlantic need not characterize its claim as a freestanding action for equitable subrogation. Accordingly, the parcel of equitable defenses the [participants] claim accompany any such action are beside the point. [Id.]

The Court could hardly have been clearer: "A subrogation lien 'is not an express lien based on agreement.' " Id. (quoting Palmer § 23.18(d), at 470). And so a case involving an ERISA reimbursement provision is not "about subrogation." Resp. Br. 13. The defenses and offsets applicable to subrogation do not apply.

Respondents make a convoluted attempt to distinguish Sereboff. They argue that the case was only about "whether the plan there had asserted a claim that was cognizable in equity," not about "what relief a plan was entitled to receive on proof of that claim." Resp. Br. 33. That is incorrect. Sereboff considered the very assertion Respondents now advance: that subrogation-based limits that alter the measure of relief, including make-whole, apply in equitable-lien-by-agreement actions. 547 U.S. at 368. And the Court rejected the idea, explaining that such limits on subrogation relief "are beside the point." Id. Respondents' theory collapses under that holding.

- 2. The standard treatises likewise reject every aspect of Respondents' argument.
- Respondents say this case is about subrogation and that subrogation and reimbursement are "governed by the same controlling principles." Resp. Br.

14 n.4 (citing Couch § 222:2). But nearly every page of their cited treatise demonstrates that is incorrect. The treatise explains that "the concepts of reimbursement and subrogation are, indeed, different both in their functioning and in their legal effect." Couch § 226:4. It explains that reimbursement is the "right of an insurer to a refund directly from the insured" while "subrogation derives from the equitable doctrine providing that the insurer * * * is placed in the position of its insured so that it may recover not from the insured, but from the third party[.]" Id. § 222:82. It explains that reimbursement "differs" from subrogation in that the reimbursement right is "derived from contractual relations." Id. § 226:1. And it explains that a health policy's reimbursement clause like the one here is an agreement "for reimbursement and not subrogation." Id. § 226:21 (emphasis added). These are just a few examples of the many pages from Respondents' treatises that disprove their assertion. See, e.g., Couch §§ 222:23, 226:3, 226:5, 226:7, 226:21; Palmer § 23.18, at 462-463, 470; see also, e.g., Unisys Med. Plan v. Timm, 98 F.3d 971, 973 (7th Cir. 1996) ("[S]ubrogation and reimbursement * * * are distinct doctrines.").

Respondents assert that "every equitable authority" says claims like Petitioner's "must be measured according to the equitable principle of unjust enrichment." Resp. Br. 2. But that is simply not so. The treatises say subrogation is measured by unjust enrichment, because it involves placing the subrogee in the subrogor's shoes to the extent warranted by the equities. 174 J. Appleman et al., Insurance Law & Practice §§ 4054, 4128 (1981). But equitable liensare "not restricted to cases of unjust enrichment." Restatement (Third) Restitution & Unjust Enrich-

ment § 56, reporter's note f (2011) (Restatement). Quite the contrary: The treatises explicitly "distinguish" the equitable lien "to prevent unjust enrichment" from the equitable lien by agreement. Dobbs § 4.3(3), at 601. The latter is different because it arises from an agreement, not from "'general considerations of right and justice." Restatement § 56, reporter's note f (citation omitted). But it is also different because the agreement itself specifies the measure of relief: "[B]y means of" the equitable lien by agreement, "the plaintiff is enabled to follow the identical thing, and to enforce the defendant's obligation by a remedy which operates directly upon that thing." Pomeroy § 1234, at 695 (emphasis added); see also id. (equitable lien by agreement "creat[es] a * * * hypothecation of the specific thing"). Indeed, Sereboff itself "emphasized that the equitable remedy" in equitable-lien-by-agreement cases "is based on the specific terms of the plan, not general unjust enrichment or other restitutionary principles." U.S. Br. 10. Respondents' contrary assertion finds no support in law.

Respondents finally assert that no matter what sort of equitable claim an ERISA plan asserts, its "relief is measured by the same specific equitable rules that applied to all subrogation-based claims," including the "double-recovery" rule. Resp. Br. 14. Again, the treatises establish otherwise (as does Sereboff). Couch, for example, says that the makewhole doctrine often is applied in subrogation, but "[w]here a policy was explicitly worded so as to require reimbursement * * * it has been held that an insurer is entitled to recovery of its payment, even though the insured has not fully recovered." Couch § 226:34 (emphases added). Couch likewise explains

that the "double-recovery" concept Respondents advance here has not been applied to reimbursement clauses: "In true subrogation cases, recovery by the insurer is generally limited to the same elements as those for which it has made payment," but "[t]his need to 'match' items of the third-party recovery to items paid by the insured appears * * * to be another area in which some courts, especially under ERISA, have determined that the language of the agreement should take precedence[.]" Id. § 226:36 (emphasis added); accord id. §§ 226:7, 226:38.

- 3. In short, Respondents' bold claim (at 12) that "[n]o credible authority concurs" with the distinction between subrogation on the one hand, and reimbursement and equitable liens by agreement on the other, is flatly wrong. In fact, every credible authority concurs. That fact destroys the remainder of their argument, for the authorities they cite discuss subrogation, not reimbursement or equitable liens by agreement. See Resp. Br. 16 (citing Couch § 222:8); id. (citing Palmer § 23.16(b)); id. at 21 (citing Svea Assurance Co. v. Packham, 48 A. 359 (Md. 1901)); id. at 23 (citing Wimberly v. American Cas. Co., 584 S.W.2d 200 (Tenn. 1979)). Svea is a pure subrogation case. See 48 A. at 360. The same is true of Wimberly. See 584 S.W. at 203. The cases have nothing to say about reimbursement or equitablelien-by-agreement measures of recovery.
- 4. Respondents advance several additional arguments in support of their subrogation theory. First, they argue repeatedly that the reimbursement agreement between Petitioner and McCutchen does not matter because the same "limitation on an insurer's recovery *** applied regardless of whether a subrogation claim was based on an express agree-

ment or simply arose by virtue of payment." Resp. Br. 19; see id. at 20-21. That may be true when it comes to subrogation. Some authorities state that the subrogation right is always grounded in unjust enrichment, such that subrogation operates the same way even when formalized by contract. See Memphis & Little Rock R.R. v. Dow, 120 U.S. 287, 301 (1887). But-again-this case does not involve a subrogation claim; it involves an equitable lien by agreement based on reimbursement. Sereboff, 547 U.S. at 365. And the law with respect to reimbursement is different. The reimbursement right, after all, is "derived from contractual relations," Couch § 226:1, and the parties have agreed to a particular bargain: One has agreed (for consideration) to turn over a specific fund to another. Equity enforces that bargain by its terms. Petr. Br. 25-26, 31-35, 41. Respondents' attempt to conflate express subrogation agreements with express reimbursement agreements should be rejected.4

Second, Respondents suggests that Petitioner is attempting to evade rules that apply uniformly to insurers. Resp. Br. 2, 19, 21. But a self-funded ERISA plan like Petitioner is not an insurer, and the benefits Petitioner offers are not an insurance plan. ERISA explicitly provides that a self-funded plan may not "be deemed to be an insurance company" for

⁴ Respondents suggest that Petitioner should suffer the consequences of choosing to "sit back" and let McCutchen sue the driver who injured him. Resp. Br. 2, 28. But this argument, too, is based on subrogation; it has no resonance in reimbursement. See Couch § 226:5 (reimbursement "is not dependent on [the insurer's] active cooperation in efforts to recover from a tortfeasor, in the absence of a positive refusal to cooperate").

state-law purposes. 29 U.S.C. § 1144(b)(2)(B). The statute preempts application of state-law insurance principles to self-funded plans, allowing them to rely on the primacy of ERISA and written plan documents. See FMC Corp. v. Holliday, 498 U.S. 52, 62 (1990). That Congressional judgment sharply undermines Respondents' effort to apply general insurance principles. And it also cuts against their proposed rule more generally: Respondents would reintroduce through the back door the very state-law doctrines Congress ousted from the field. That is a patently illogical understanding of the statute.

Third, Respondents rely on Great-West Life & Annuity Insurance Co. v. Knudson, 534 U.S. 204, 211 n.1 (2002), for the proposition that relief on a reimbursement claim "is measured by the same specific equitable rules that applied to all subrogation-based claims." Resp. Br. 14. That is wrong. The cited footnote contains neither the words "reimbursement" nor "subrogation," and stands for the unremarkable proposition that a claim for equitable relief must meet the requirements that attach to it; otherwise it is unavailable. There is no dispute that the relief sought here, an equitable lien by agreement, meets equitable requirements and was typically available in equity.

Finally, Respondents advance a series of farfetched hypotheticals, telling the Court that under Petitioner's rule, plans could draft reimbursement provisions requiring participants to give back "five, ten, or even one-hundred times" what the plan paid. Resp. Br. 35-36. But Respondents cannot point to a case where anything remotely like this has happened. And if it did, courts would have tools to address the problem. For one, courts have suggested that an equitable lien by agreement would be unenforceable where the agreement constituted usury. Petr. Br. 36.

The bottom line: Respondents' effort to use subrogation, unjust enrichment, and insurance principles as a shield against Section 502(a)(3) and Sereboff cannot withstand scrutiny. The reimbursement agreement should be enforced by its terms, without offsets for "double recovery" or otherwise.

II. THE COMMON-FUND DOCTRINE DOES NOT APPLY.

Respondents double down on their flawed unjustenrichment argument when it comes to common fund: "Like the double recovery cap," they say, "the common fund rule rests on the principle of unjust enrichment." Resp. Br. 26. That is correct. And that is precisely why the rule does not apply. Instead, just as with the double-recovery analysis, ERISA itself and equitable-lien-by-agreement principles require that the plan's terms be enforced as written.

1. Here, as above, the analytical guideposts are the statute and the law of equitable lien by agreement. Neither makes any room to import a "common fund" reduction when that reduction contradicts plan terms. As discussed, Section 502(a)(3) authorizes appropriate equitable relief to "enforce * * * the terms of the plan," not to override them. 29 U.S.C. § 1132(a)(3). And ERISA is designed to effectuate plans, not eviscerate them. v. Egelhoff, 532 U.S. 141, 150 (2001). Respondents would undercut that design, authorizing courts to second-guess plan administrators' decisions without clear statutory authority. This improperly diminishes the primacy of written plan documents.

NASP Amici Br. 10-11; Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan, 555 U.S. 285, 300 (2009).

That is why every circuit to consider the questionuntil the Ninth Circuit's recent decision in CGI Technologies & Solutions v. Rose, 683 F.3d 1113 (9th Cir. 2012)—rejected the idea that the common-fund doctrine applies to an ERISA plan whose terms decline to incorporate common-fund principles. See, e.g., Harris v. Harvard Pilgrim Health Care, Inc., 208 F.3d 274, 279 (1st Cir. 2000); Ryan v. Federal Express Corp., 78 F.3d 123, 127-128 (3d Cir. 1996); United McGill Corp. v. Stinnett, 154 F.3d 168, 173 (4th Cir. 1998); Bombardier Aerospace Emp. Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough, 354 F.3d 348, 361-362 (5th Cir. 2003); Health Cost Controls v. Isbell, 139 F.3d 1070, 1072 (6th Cir. 1997); Administrative Comm. of Wal-Mart Stores. Inc. v. Varco, 338 F.3d 680, 692 (7th Cir. 2003); Zurich Am. Ins. Co. v. O'Hara, 604 F.3d 1232, 1237 n.4 (11th Cir. 2010). As the Seventh Circuit explained: "[O]ne of ERISA's primary purposes is to ensure the integrity of written plans. * * * Therefore, it is inappropriate to fashion a common law rule that would override the express terms of a private plan[.]" Varco, 338 F.3d at 692. And notably, in this case, the Third Circuit did not announce it accepted the doctrine either.

The equitable-lien-by-agreement cases require the same result. Respondents offer nothing to dispute our showing (Petr. Br. 33-37) that courts sitting in equity did not apply the common-fund rule or other offsets in equitable-lien-by-agreement cases. And they have not cited a single pre-McCutchen case that stands for the proposition that an equitable lien by agreement is subject to a common-fund offset when

the agreement itself prohibits application of the doctrine. That is because, to our knowledge, there is no such case; equity enforced such agreements by their terms. See supra at 7-13. Indeed, even Respondents' preferred treatise and one of their own cited cases recognize that the common-fund doctrine may be overcome by "an agreement to the contrary." Couch § 223:113 (emphasis added); accord State Farm Mut. Auto. Ins. Co. v. Clinton, 518 P.2d 645, 658 (Or. 1974). Just so. Respondents cannot cast aside the unambiguous Plan language forbidding them from "negotiat[ing] any agreements with a third party that would undermine" the Plan's rights. J.A. 20.

2. Respondents' contrary theory is based, yet again, on unjust enrichment and subrogation. They admit, correctly, that the common-fund doctrine "rests on the principle of unjust enrichment." Resp. Br. 26; see Boeing Co. v. Van Gemert, 444 U.S. 472. 478 (1980). But as we have shown, equitable liens by agreement do not rest on unjust enrichment; they rest on agreement. Respondents likewise claim that the "overwhelming majority of decisions" embraces the common-fund doctrine. Resp. Br. 27. But by that Respondents mean an overwhelming majority of subrogation decisions; their cited authorities nearly all arise in that context. See id. at 26-30 & nn.10-11. When it comes to authority actually relevant herenamely, equitable-lien-by-agreement cases and cases applying ERISA reimbursement provisions—the "overwhelming majority of decisions" comes out the other way. The equitable-lien-by-agreement cases do not embrace the common-fund doctrine. And Courts of Appeals considering common fund's applicability to ERISA reimbursement provisions have almost uniformly rejected it. See supra at 15.

Indeed, in rejecting common fund, courts have criticized the approach Respondents take: conflating reimbursement and subrogation. The First Circuit in Harris, for example, rejected a participant's reliance on a subrogation decision. Waller v. Hormel Foods Corp., 120 F.3d 138 (8th Cir. 1997), that embraced common fund. "[Rleimbursement and subrogation are distinct remedies," the court wrote. "Waller held simply that a plan member might interpret the term 'subrogation' to mean that 'the Plan will pay reasonable fees and expenses so as to encourage beneficiaries to press claims to which the Plan will be partially subrogated.' No such inference would be compelled, however, were the plan to seek recovery, not through subrogation, but independently, based on its own right to direct reimbursement." Harris, 208 F.3d at 278 (citation omitted; emphasis added). Respondents' claim to enjoy "overwhelming" precedential support rests on inappropriate conflation of separate lines of authority.

Moreover, even if unjust-enrichment principles applied, there would be no unjust enrichment here because "one who is enriched by what he is entitled to under a contract or otherwise is not unjustly enriched." Dobbs § 4.1(2), at 558; accord Restatement § 2 cmt. c; Ryan, 78 F.3d at 127. The U.S. Airways Plan, like every ERISA plan, is a bargain involving tradeoffs on each side. Nothing in ERISA required U.S. Airways to cover McCutchen's medical payments in the first instance, and as the Seventh Circuit has explained, the tradeoff participants make in accepting benefits under a reimbursement provision like the one here is sensible: They trade the

possibility of a "common-fund-type" reduction for the certainty of having medical benefits paid up front in third-party-liability situations. Varco, 338 F.3d at 692 (citing Cutting v. Jerome Foods, Inc., 993 F.2d 1293, 1297-98 (7th Cir. 1993) (Posner, J.)). They "in effect trad[e] an uncertain bundle of tort rights for a larger certain right, which is just the sort of trade that people seek through insurance." Cutting, 993 F.2d at 1297-98. Participants should be held to that bargain. "[A]ny so-called enrichment" that flows to either party as a result "is not unjust." Varco, 338 F.3d at 692.

- 3. The United States supports Petitioner throughout most of its brief, explaining that "[t]he plan terms, not unjust enrichment principles * * * define the parties' rights and responsibilities," and that the Court accordingly should reject the double-recovery rule and enforce the Plan as written. U.S. Br. 16, 12-And yet when it comes to the common-fund doctrine, the United States reverses itself; suddenly, it would allow unjust-enrichment principles to trump plan terms. Id. at 21-30. There is no justification for (or logic to) this about-face. The United States' recognition that the statute and equitable-lien-byagreement principles govern is correct. Its attempt to carve out a common-fund exception should be rejected.
- a. By way of explanation for its mid-course reversal, the United States maintains that the commonfund doctrine is a "core" equitable principle and is therefore somehow "different" from other, "general" equitable principles such as the double-recovery doctrine. *Id.* at 13, 21, 26. It cites no authority to support that unlikely proposition. And it has argued directly to the contrary before. The Secretary of

Labor argued in *Bombardier*, supra, that "the terms of the plan should override any 'common fund' doctrine that may otherwise be available[.]" Brief of *Amicus Curiae* Elaine L. Chao 21, *Bombardier*, No. 03-10195, 2003 WL 23472065. The United States offers no explanation for its change in position other than to say it is the result of "further reflection." U.S. Br. 23 n.9.

The government's new position does not even flow from its new logic. It suggests that the parties' "core relationship involving benefits" is "properly defined by the plan" but that "when the question shifts away from *** the terms of the plan," the court's background equitable powers take over. U.S. Br. 26. But the "question" does not "shift[] away" from the plan terms when it comes to attorneys' fees. The U.S. Airways Plan requires full reimbursement and expressly forbids participants from entering into agreements with third parties that impair the Plan's rights. J.A. 20. By the United States' own logic, the common-fund doctrine has no application here.

b. The United States points out that in a number of federal statutes, Congress has chosen to limit beneficiaries' reimbursement obligations to account for attorneys' fees. U.S. Br. 28-33; see, e.g., 5 U.S.C. § 8132. The United States apparently views these statutory implementations of common-fund principles as evidence that Congress favors the doctrine. See U.S. Br. 28. But the statutes in fact demonstrate a different point: When Congress intends to limit reimbursement obligations and apply the commonfund doctrine, it does so expressly. It did not do so in ERISA. That silence is significant, particularly in the context of a statute where "Congress did not intend to authorize other remedies that it simply

forgot to incorporate expressly." Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 146 (1985). Compare Fleischmann Distilling Corp. v. Maier Brewing Co., 386 U.S. 714, 719-721 (1967) (finding similar intent in Lanham Act and refusing to apply common-fund doctrine), with Hall v. Cole, 412 U.S. 1, 9-10 (1973) (finding no such intent in Labor-Management Reporting and Disclosure Act and therefore applying common-fund doctrine). Respondents would have this Court do what Congress declined to do. But the Court has demonstrated great "reluctan[ce] to tamper" with ERISA's carefully crafted enforcement scheme. Russell, 473 U.S. at 147. It should follow that course here as well.

4. Respondents and their amici advance several policy arguments for why the common-fund doctrine should override agreed-to plan terms.

First, they assert that in the absence of a commonfund principle, some plan participants may make the strategic decision not to bother suing tortfeasors who injured them, thus deterring socially beneficial suits. Resp. Br. 30. But that is no reason not to enforce the parties' bargain. Plans—in collaboration with participants—should be free to decide what terms the plans should contain. If those terms create unwelcome incentives, they can be reconsidered over time to reflect marketplace realities.⁵

Next, Respondents argue that enforcing the plan is unfair to McCutchen and his attorneys. Resp. Br. 30-31. Not so. McCutchen traded the possibility of a common-fund reduction for "the guarantee that

⁵ For that matter, plans are free to draft their terms in such a way as to *adopt* the common-fund rule. The rule Petitioner advances would simply let plan terms govern.

medical bills will be paid immediately." Varco, 338 F.3d at 692. As for his attorneys, their fees are governed by their separate contract with McCutchen. And McCutchen and his attorneys knew the Plan required reimbursement and pursued third-party recovery anyway. McCutchen cannot "partake of the benefits of the Plan and then *** invoke common law principles to establish a legal justification for [his] refusal to satisfy [his] end of the bargain." Ryan, 78 F.3d at 128.

Finally, Respondents' amici suggest that the basic principle on which Petitioner relies-that people should be held to their promises—does not apply here because an ERISA plan is essentially a contract of adhesion. See United Policyholders Br. 11. That argument is flawed for many reasons. First, the U.S. Airways Plan was collectively bargained. Appendix 201. Second, McCutchen was never forced to accept payment for his medical costs; he did so under Plan terms that required reimbursement. Finally, the adhesion argument has no resonance in the common-fund context; any time a third-party tort recovery is in the offing, the participant's counsel will know there is a potential lien on any recovery and will take that into account before deciding whether to take the case. Respondents' own amici confirm as much. Consumer Watchdog Br. 25. McCutchen's attorneys knew of the potential lien. And they took the case. That informed choice does not provide a rationale for ignoring plan language.6

⁶ Even if the common-fund doctrine could apply to ERISA reimbursement in some circumstances, moreover, it cannot apply here. "A party may not recover and try to monopolize a fund, but then, failing in the attempt, declare it a 'common

III. RESPONDENTS' RULE WOULD IMPOSE NEW BURDENS ON PLANS, PARTICIPANTS, AND COURTS.

Respondents and their amici offer various reasons why their approach would do no harm. Each is wrong.

1. First, Respondents dispute the notion that reimbursements impact plan premiums. Resp. Br. 50. But numerous courts and commentators have concluded otherwise. See Petr. Br. 27-28, 43-44. Their conclusions are supported by actuarial practice: Governing standards instruct that when actuaries engage in "development of rates," they must "take into account" reimbursement and subrogation recoveries "and make appropriate adjustments." Actuarial Standards Board, Actuarial Standard of Practice No. 5. Incurred Health & Disability Claims § 3.3.5. at 6 (effective May 1, 2011).7 They are also supported by common sense. Self-funded ERISA plans cover their own costs. And plans recover some \$1 billion annually under reimbursement provisions. Petr. Br. 42-43. If plans lose some portion of those reimbursements under Respondents' rule, that money will need to come from somewhere.

fund' and obtain his expenses from those whose rightful share of the fund he sought to appropriate." United States v. Tobias, 935 F.2d 666, 668 (4th Cir. 1991); Hobbs v. McLean, 117 U.S. 567, 581-582 (1886). That is what Respondents did here. They avoided informing the Plan of their settlement negotiations and, once their settlement was discovered, assiduously sought to eliminate the Plan's recovery. See J.A. 34 ¶¶ 4-6.

⁷ Available at http://www.actuarialstandardsboard.org/pdf/asops/asop005_126.pdf.

The most likely outcome is that the shortfall will be built into rates (thus imposing costs on other participants) or that plans will cease to advance medical expenses in third-party-liability cases. The other possibility is that plan sponsors will absorb the shortfall. In many cases, of course, that will not be fatal, but in some it may well cost employees their coverage. After all, even a one percent cost increase can translate to 315,000 employees losing health coverage. NASP Amici Br. 29. And despite Respondents' attempts to minimize the impact of their rule, substantial plan savings are at stake here. See Blue Cross Amici Br. 4.

- 2. Respondents also argue there is no evidence their approach would increase administrative costs. But they have nothing to say about Wisconsin's system of mini-trials that does just that. Petr. Br. 47-48. Moreover, this Court has long recognized that "[t]he time, expense, and difficulties of proof inherent in litigating the question of what constitutes reasonable attorney's fees * * * pose substantial burdens for judicial administration." Fleischmann, 386 U.S. at 718.
- 3. Finally, Respondents do not even attempt to answer Petitioner's final practical point: that their rule undermines Congress's effort to create a statutory regime guaranteeing predictable liabilities. Petr. Br. 26-28. Their silence is telling. Respondents' rule is "fundamentally at odds with the goal of uniformity that Congress sought to implement," Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990), and this Court should reject it.

CONCLUSION

For the foregoing reasons, and those in the opening brief, the decision below should be reversed.

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November 2012

AMICUS CURIAE BRIEF

In the Supreme Court of the United States

U.S. AIRWAYS, INC., IN ITS CAPACITY AS FIDUCIARY AND PLAN ADMINISTRATOR OF THE U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN, PETITIONER

2)

JAMES E. MCCUTCHEN, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING NEITHER PARTY

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QUESTIONS PRESENTED

Section 502(a)(3) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1132(a)(3), authorizes a participant, beneficiary, or fiduciary to bring a civil action to enjoin any act or practice that violates ERISA or the terms of an ERISA plan or "to obtain other appropriate equitable relief to redress such violations or to enforce any provisions of [ERISA] or the terms of the plan." In this case, a fiduciary brought an action under Section 502(a)(3) to enforce a plan term requiring a participant to reimburse the plan for plan-paid medical expenses out of any funds recovered from a third party responsible for the participant's injuries.

The questions presented are:

1. Whether the participant's reimbursement obligation is subject to a pro rata reduction under general unjust enrichment principles because he did not receive a full recovery from the third party.

2. Whether the equitable common-fund doctrine should govern the allocation of responsibility for the attorney's fees the participant incurred in securing the recovery from which the fiduciary seeks reimbursement.



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In the Supreme Court of the United States

No. 11-1285

U.S. AIRWAYS, INC., IN ITS CAPACITY AS FIDUCIARY AND PLAN ADMINISTRATOR OF THE U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN, PETITIONER

v.

JAMES MCCUTCHEN, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING NEITHER PARTY

INTEREST OF THE UNITED STATES

The questions presented in this case concern the scope of "appropriate equitable relief" available in a civil action by a plan fiduciary under Section 502(a)(3) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1132(a)(3). The Secretary of Labor (Secretary) has primary enforcement authority under ERISA and similar authority to bring a civil action for "appropriate equitable relief" under Section 502(a)(5) of the statute, 29 U.S.C. 1132(a)(5). Accordingly, the Court's consideration of the term "appropriate equitable relief" may affect not only the scope of private civil actions under Section 502(a)(3), which are a necessary complement to actions by the Secretary,

but also the scope of the Secretary's own authority under Section 502(a)(5).

STATEMENT

1. In January 2007, James McCutchen (respondent) suffered serious injuries when another driver lost control of her car and struck the car respondent was driving. Pet. App. 3a, 19a. At the time, respondent was an employee of U.S. Airways and a participant in the company's self-funded health plan (the plan). *Id.* at 19a. The plan paid \$66,866 in accident-related medical expenses on respondent's behalf. *Id.* at 3a.

Respondent, through attorneys at Rosen, Louik & Perry, P. C. (also respondents here), filed a negligence suit against the other driver. Pet. App. 3a. In June 2007, Ingenix Subrogation Services notified respondent's attorneys that it had been retained by the plan to recover the accident-related medical benefits the plan had paid on respondent's behalf. *Id.* at 19a. The plan relied on the following provision in its Summary Plan Description (SPD), titled "Subrogation and Right of Reimbursement":

The purpose of the Plan is to provide coverage for qualified expenses that are not covered by a third party. If the Plan pays benefits for any claim you incur as the result of negligence, willful misconduct, or other actions of a third party, the Plan will be subrogated to all your rights of recovery. You will be required to reimburse the Plan for amounts

¹ If petitioner's plan had been insured, Pennsylvania law would have barred subrogation. See *FMC Corp.* v. *Holliday*, 498 U.S. 52, 61 (1990) (discussing 75 Pa. Cons. Stat. § 1720 (1987)). Because petitioner's plan is self-funded, however, that state law is preempted. See *id.* at 65.

paid for claims out of any monies recovered from a third party, including, but not limited to, your own insurance company as the result of judgment, settlement, or otherwise. In addition you will be required to assist the administrator of the Plan in enforcing these rights and may not negotiate any agreements with a third party that would undermine the subrogation rights of the Plan.

Id. at 4a-5a (emphasis omitted).2

The other driver had limited insurance coverage, and three people in addition to respondent were seriously injured or killed in the accident. Pet. App. 3a, 20a. Accordingly, respondent settled his claim against the other driver for only \$10,000. Id. at 3a. With assistance from his attorneys, respondent and his wife received from his own automobile insurer another \$100,000, which was the maximum available under his underinsured driver coverage. Id. at 3a, 20a.

After paying expenses and a 40% contingency fee to his attorneys, respondent's net recovery was approximately \$66,000. Pet. App. 3a. Respondent's attorneys, who "reason[ed] that any lien [by the plan] found to be valid would have to be reduced by a proportional amount of legal costs," placed \$41,500 in a trust account for possible payment to the plan and disbursed additional funds to respondent. *Id.* at 4a, 20a.

The SPD "provide[s] communication with beneficiaries about the plan, but * * * [its] statements do not themselves constitute the terms of the plan," CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1878 (2011), and the plan itself is not in the record. Nonetheless, the parties and courts below have treated the SPD provisions as accurately reflecting the relevant plan terms.

2. After respondent did not comply with the plan's reimbursement demand, U.S. Airways, in its capacity as the plan administrator and therefore a plan fiduciary (petitioner), sued respondent and his attorneys under ERISA Section 502(a)(3). Pet. App. 4a. As relevant here, that provision authorizes a civil action by an ERISA "fiduciary * * * to enjoin any act or practice which violates any provision of [Subchapter I of ERISAl or the terms of the plan, or * * tain other appropriate equitable relief * * dress such violations or * * to enforce any provisions of this subchapter or * * the terms of the plan." 29 U.S.C. 1132(a)(3). Petitioner sought as "appropriate equitable relief" the \$66,866 in plan-paid medical expenses, i.e., the \$41,500 held in trust plus \$25,366 from respondent. Pet. App. 4a-5a.

The district court granted summary judgment to petitioner, rejecting each of respondent's arguments for limiting petitioner's recovery to less than the full

amount it sought. Pet. App. 18a-35a.

4. The court of appeals vacated the district court's order and remanded for further proceedings. Pet. App. 2a. The court reasoned that although petitioner sought "equitable relief" under 29 U.S.C. 1132(a)(3), courts must exercise their discretion to limit that relief to what is "appropriate." Pet. App. 9a. In the court's view, that meant that a plan cannot equitably enforce a plan term if traditional equitable principles would deny or limit such relief. *Id.* at 9a-12a.

"Applying the traditional equitable principle of unjust enrichment," the court "conclude[d] that the judgment requiring [respondent] to provide full reimbursement to [petitioner] constitutes inappropriate and inequitable relief." Pet. App. 16a. The court was

of the view that full reimbursement would "amount[] to a windfall for [petitioner], which did not exercise its subrogation rights or contribute to the cost of obtaining the third-party recovery." *Ibid.* The court further stated that full reimbursement would "undermin[e] the entire purpose of the Plan," "[b]ecause the amount of the judgment exceeds the net amount of [respondent's] third-party recovery" after the deduction of attorney's fees and "leaves him with less than full payment for his emergency medical bills." *Ibid.*

The court declined to "decide on appeal what would constitute appropriate equitable relief for [petitioner] because 'equity calls for full factual findings rather than [the court of appeals'] speculation." Pet. App. 17a (citation omitted). Instead, the court remanded to the district court to "exercise its discretion under § 502(a)(3)." *Ibid.* (quoting CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1880 (2011)).

SUMMARY OF ARGUMENT

Section 502(a)(3) of ERISA authorizes "appropriate equitable relief * * * to enforce * * * the terms of [an ERISA] plan." 29 U.S.C. 1132(a)(3). The provision is best read to recognize both the centrality of plan terms to ERISA and their enforceability, while at the same time preserving the historic powers of equity courts to equitably allocate attorney's fees.

1. Section 502(a)(3) authorizes "appropriate equitable relief," not in the abstract, but to enforce "any provision of this subchapter or the terms of [a] plan." 29 U.S.C. 1132(a)(3). The Court has explained that a plan may invoke this provision to enforce a plan term requiring a participant to reimburse the plan for covered expenses when the participant recovers from a third party for the accident that caused them. Such a

suit seeks "appropriate equitable relief" because it is analogous to a suit in equity to enforce an equitable lien by agreement. See Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356, 363-364 (2006).

Equitable liens by agreement are fundamentally different than equitable liens imposed as a restitutionary remedy to prevent unjust enrichment. As the name suggests, the basis for enforcement of an equitable lien by agreement is the agreement itself. Accordingly, in such an enforcement action, the agreement, not general restitutionary principles of unjust enrichment, provides the measure of relief due. This conclusion is confirmed not only by this Court's discussion of the scope of Section 502(a)(3) in Sereboff, but also by equity treatises this Court has consulted when construing that provision.

This analysis is unaltered by Section 502(a)(3)'s requirement that "equitable relief" be "appropriate." 29 U.S.C. 1132(a)(3). Contrary to the court of appeals' conclusion, inclusion of the word "appropriate" in this provision does not provide courts license to invalidate or decline to enforce plan provisions otherwise permitted by ERISA. Instead, the requirement that equitable relief be "appropriate" performs more limited roles under the Act. It ensures that a remedy is not provided under Section 502(a)(3), a "catch-all," if it should instead be pursued under one of ERISA's more specific remedial provisions. See Varity Corp. v. Howe, 516 U.S. 489, 515 (1996). It also contemplates that the court will choose a suitable remedy from among the range of possible "equitable relief." A court applying equitable principles would not have broad discretion to decline to enforce an equitable lien by agreement based on the court's case-specific judgments about what fairness and equity require. Equity itself requires that the lien be enforced according to its terms.

Given the beneficiary's obligation "to reimburse the Plan for amounts paid for claims out of any monies recovered from a third party," Pet. App. 4a, respondent has no right to pro rata reduction in his reimbursement obligation on the ground that his recovery for his accident did not fully compensate him for his losses. And, in any event, enforcing the plan's reimbursement provision as written to require respondent to fully reimburse petitioner would not be inconsistent with equitable principles. Enforcement of the plan term is equitable to participants and beneficiaries as a class because it reduces plan expenses, and is equitable to respondent in particular because the reimbursement obligation was part of a quid pro quo for his immediate receipt of plan benefits even though a third party was responsible for his injuries.

2. Respondent's claim that the attorney's fees he incurred in securing his third-party recovery should be equitably apportioned with petitioner stands on a different footing than his more general invocation of equitable principles. In that limited area, the historic powers of the equity court to require parties that received a valuable benefit from litigation to share in the expense of procuring it is not overridden by plan

terms that purport to negate those powers.

"The common-fund doctrine reflects the traditional practice in courts of equity." Boeing Co. v. Van Gemert, 444 U.S. 472, 478 (1980). That doctrine, first articulated 130 years ago in Trustees v. Greenough, 105 U.S. 527 (1882), and applied repeatedly since, authorizes courts in equity to require an absent party to

contribute to a litigant's attorney's fees when that litigant secures a fund or other valuable benefit for the absent party. The doctrine is rooted in the understanding that such attorney's fees are properly shared because they were necessary for the very creation and maintenance of the fund at issue. In that regard, the Court has analogized a litigant's entitlement to fees to a trustee's entitlement to be reimbursed for his expenses from the fund he administers.

Under the tort litigation that is the predicate for a reimbursement action, the beneficiary is effectively conducting litigation on behalf of the plan, and the plan, rather than exercising its subrogation rights to vindicate its own interests, decides to stand aside and accept that valuable benefit of representation from the participant. That is a familiar fact pattern at equity, and when confronted with it, courts applied the common-fund doctrine to account for the valuable benefit.

An action for "appropriate equitable relief" under Section 502(a)(3) takes the core powers of the court in equity as it finds them, and among those powers is the ability to apportion attorney's fees in cases like this one. A plan term cannot take that power away, just as a plan term could not purport to deprive the court of its power to issue an injunction or grant another traditional equitable remedy.

ARGUMENT

ERISA SECTION 502(a)(3) AUTHORIZES RELIEF THAT ENFORCES PLAN TERMS BUT RECOGNIZES SETTLED POWERS OF COURTS IN EQUITY OVER APPORTIONMENT OF ATTORNEY'S FEES

Section 502(a)(3) of ERISA authorizes a participant, beneficiary, or fiduciary to bring a civil action

"to obtain * * * appropriate equitable relief
* * * to enforce * * * the terms of the plan."
29 U.S.C. 1132(a)(3). This provision allows a fiduciary
to enforce the lawful "terms of the plan" conditioning
the benefits it provides, while at the same time leaving
undisturbed the core powers of a court of equity to
equitably apportion attorney's fees.

- A. In A Section 502(a)(3) Enforcement Action, The Parties' Benefits-Based Obligations To Each Other Are Defined By The Plan
- 1. This Court has interpreted the phrase "equitable relief" in 29 U.S.C. 1132(a)(3) to encompass, in a suit against a non-fiduciary, only those categories of relief that "were typically available in equity" before the merger of law and equity, such as "injunction, mandamus, and restitution." Mertens v. Hewitt Assocs., 508 U.S. 248, 256 (1993); see CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1878 (2011). Although courts at equity also had the power under certain circumstances to "establish purely legal rights and grant legal remedies which would otherwise be beyond the scope of [their] authority," the Court has interpreted Section 502(a)(3) not to incorporate such legal remedies. Mertens, 508 U.S. at 256-257 (quoting 1 John N. Pomeroy, A Treatise on Equity Jurisprudence § 181, at 257 (5th ed. 1941)).
- a. The Court has twice applied these principles to a suit, like this one, seeking reimbursement from a beneficiary. In *Great-West Life & Annuity Insurance Co.* v. *Knudson*, 534 U.S. 204 (2002) (*Great-West*), the Court concluded that a plan sought legal relief not available under 29 U.S.C. 1132(a)(3) by seeking, "in essence, to impose personal liability on [participants]

for a contractual obligation to pay money-relief that was not typically available in equity." 534 U.S. at 210.

By contrast, in Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356 (2006), the Court concluded that the "impediment to characterizing the relief in [Great-West] as equitable [was] not present" because the plan sought an "equitable lien on a specifically identified fund, not from the [beneficiaries'] assets generally, as would be the case with a contract action at law." Id. at 362-363. The Court further concluded that the basis for the plan's claim was equitable because it was based on a "familiar rul[e] of equity" allowing enforcement of a contract to convey a specific object after it is acquired. Id. at 363-364 (quoting Barnes v. Alexander, 232 U.S. 117, 121 (1914)).

Sereboff emphasized that the equitable remedy authorized by Section 502(a)(3) in those circumstances is based on the specific terms of the plan, not general unjust enrichment or other restitutionary principles. The plan beneficiaries in that case contended that the plan had no equitable remedy against them because the plan's claim did not "satisf[y] the conditions for 'equitable restitution' at common law." 547 U.S. at The Court concluded that the beneficiaries' premise was incorrect: "an equitable lien sought as a matter of restitution" was not at issue in the case. Id. at 364-365. Instead, the plan sought "an equitable lien 'by agreement," which is a "different species of re-Accordingly, "the restitutionary condilief." Ibid. tions" that applied in equity to a claim for equitable restitution were inapposite to the plan's suit for reimbursement. Id. at 365.

The Court in Sereboff likewise rejected the beneficiaries' contention that the plan could not enforce the

plan's reimbursement obligation "without imposing various limitations that they sa[id] would apply to 'truly equitable relief grounded in principles of subrogation." 547 U.S. at 368. Again, the beneficiaries' premise was incorrect: the plan's "claim [was] not considered equitable because it [was] a subrogation claim." Ibid. Instead, enforcement of the plan's reimbursement provision "qualifie[d] as an equitable remedy because it [was] indistinguishable from an action to enforce an equitable lien established by agreement." Ibid. The Court explained that "the parcel of equitable defenses" offered by the beneficiaries, including their argument that they should not be required to reimburse the plan because they had not yet been "made whole" for their injuries, was thus "beside the point"-those defenses did not apply even as a matter of equity. Ibid.

b. The availability of a remedy for enforcement of a plan's reimbursement provision under Section 502(a)(3), so long as it satisfies the conditions for some form of typical equitable relief, is consistent with ERISA's overall focus on the centrality of plan terms. See Sereboff, 547 U.S. at 363 ("ERISA provides for equitable remedies to enforce plan terms, so the fact that [an] action involves a breach of contract can hardly be enough to prove relief is not equitable; that would make § 502(a)(3)(B)(ii) an empty promise."); see generally Amara, 131 S. Ct. at 1878-1882. Section 502(a)(3) "does not, after all, authorize 'appropriate equitable relief' at large, but only 'appropriate equitable relief' for the purpose of 'redress[ing any] violations or . . . enforc[ing] any provisions' of ERISA or an ERISA plan." Mertens, 508 U.S. at 253 (quoting 29 U.S.C. 1132(a)(3)).

"As this Court long ago recognized, 'there is inherent in the Courts of Equity a jurisdiction to . give effect to the policy of the legislature." Mitchell v. Robert DeMario Jewelry, Inc., 361 U.S. 288, 292 (1960) (quoting Clark v. Smith, 38 U.S. (13 Pet.) 195, 203 (1839)). And one of those policies under ERISA is "to protect contractually defined benefits." Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985). ERISA thus provides that a fiduciary is to "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and in accordance with the documents and instruments governing the plan insofar as" they are consistent with ERISA. 29 U.S.C. 1104(a)(1) (emphasis added). The statute also requires that "[e]very employee benefit plan shall be established and maintained pursuant to a written instrument." 29 U.S.C. 1102(a)(1).

"ERISA comprehensively regulates, among other things, employee welfare benefit plans," and "[t]he civil enforcement scheme of § 502(a) is one of the essential tools for accomplishing the stated purposes of ERISA." Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44, 52 (1987). ERISA, however, does not generally "regulate the substantive content of welfare-benefit plans." Inter-Modal Rail Employees Ass'n v. Atchison, Topeka, & Santa Fe Ry., 520 U.S. 510, 515 (1997) (quoting Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 732 (1985)). And this Court has resisted

³ Congress has amended ERISA to impose certain requirements on group health plans. See 29 U.S.C. 1181-1185b (2006 & Supp. IV. And, under certain circumstances, the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1513, 124 Stat. 253-256, will impose assessable payments on large employers that, begin-

encroachment of state and federal common law principles that "might obscure a plan administrator's duty to act 'in accordance with the documents and instruments." Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan, 555 U.S. 285, 303 (2009) (quoting 29 U.S.C. 1104(a)(1)). It would be inconsistent with Congress's judgment generally eschewing regulation of the substantive content of ERISA plans to give such authority to courts in the guise of broad equitable discretion not to enforce the terms of the plan as written.

2. The court of appeals nonetheless concluded that Section 502(a)(3)'s requirement that equitable relief be "appropriate" gave courts discretionary authority to apply their views of general equitable principles to limit relief to enforce lawful plan terms. Pet. App. 9a-12a; see Sereboff, 547 U.S. at 368 n.2 (declining to address participant's argument that relief was not "appropriate" under Section 502(a)(3) "in that it contravened principles like the make-whole doctrine"). The court was mistaken. The word "appropriate" in Section 502(a)(3) does not grant courts broad powers to decline to enforce plan terms governing benefits and the conditions attaching to their provision. Instead, the requirement that equitable relief be "appropriate" serves more circumscribed purposes.

As the Court has explained, Section 502(a)(3) plays a special role in ERISA's remedial scheme. It is a "catchall," affording relief for violations that the other subsections of Section 502 do not adequately remedy. Varity Corp. v. Howe, 516 U.S. 489, 512 (1996). Ac-

ning in 2014, do not offer adequate group coverage to full-time employees. See 26 U.S.C. 4980H (Supp. IV 2010); see also 26 U.S.C. 4980D (imposing tax on failure of group health plan to meet certain requirements).

cordingly, "we should expect that where Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief." Id. at 515. Under those circumstances, "relief normally would not be 'appropriate'" under Section 502(a)(3). Ibid. That is because contractuallydefined benefits are normally obtained under Section 502(a)(1)(B), 29 U.S.C. 1132(a)(1)(B), in a suit by a participant or beneficiary "to recover benefits due to him under the terms of his plan," while a suit to recover losses to a plan caused by a fiduciary's failure to follow plan terms is to be brought under Section 502(a)(2), 29 U.S.C. 1132(a)(2). Neither of those enforcement provisions lends itself to a suit by a fiduciary to enforce a plan's reimbursement rights against a participant or beneficiary. Thus, in this case, equitable relief on the part of the plan is "appropriate" under Section 502(a)(3) because no other remedial provision of ERISA provides a more specific mechanism for enforcing respondent's reimbursement obligation.

Moreover, because a court in a Section 502(a)(3) suit can invoke a broad array of remedies typically available in equity, the word "appropriate" serves the further purpose of directing the court to choose a particular remedy that is well suited to the circumstances. Here, under *Sereboff*, there can be no question that enforcement of an equitable lien by agreement is

an "appropriate" remedy in this sense as well.

3. Because petitioner's suit under Section 502(a)(3) is one to enforce an equitable lien by agreement, respondent's obligation to petitioner is determined by the plan, not by general unjust enrichment or other principles of equitable restitution.

As the Court explained in Sereboff, a claim for reimbursement like this one does not seek enforcement of "an equitable lien sought as a matter of restitution" but instead an "equitable lien 'by agreement." 547 U.S. at 364-365 (emphasis added). The sources that this Court consults when construing the phrase "appropriate equitable relief" in Section 502(a)(3) (see Great-West, 534 U.S. at 217; Amara, 131 S. Ct. at 1879) make clear that enforcement of an equitable lien by agreement entails enforcement of the agreement as written, not imposition of general unjust enrichment principles.

Dobbs's remedies treatise explains that, in equity, the term "equitable lien" is used in "two fairly disparate senses." Dan B. Dobbs, Law of Remedies § 4.3(3), at 401 (2d ed. 1993) (Dobbs). An equitable lien by agreement is "equitable' in the sense that [the liens] may have failed to comply with some requirement for establishment of a 'common law' lien" and could therefore be "recognized and enforced in the courts of equity." Id. at 402. But the basis for such a lien, and the parties' respective obligations under it, is in the agreement itself. See *ibid*. The equitable lien by agreement is thus distinct from the second category of equitable lien, which a court in equity could apply without an agreement in order "to prevent unjust enrichment." Ibid.⁴

Dobbs also notes that subrogation at equity had similarly parallel meanings. "Subrogation, like lien, trust, and contract, may arise by express or implied-in-fact agreement of parties, in which case it is called conventional subrogation." Dobbs § 4.3(4), at 405. In contrast, "[s]ubrogation may also arise because it is imposed by courts to prevent unjust enrichment, in which case it is called legal or equitable subrogation." Ibid.

The Pomeroy treatise likewise distinguishes between the two types of equitable liens. That treatise notes that equitable liens may be "created by executory contracts which, in express terms, stipulate that property shall be held, assigned, or transferred as security for the promisor's debt or other obligation." 4 John N. Pomeroy, A Treatise on Equity Jurisprudence § 1239, at 711 (5th ed. 1941). Equitable liens may also be created "without agreement therefor between the parties," and, in that second category of liens, the parties "must recognize and admit the equitable rights of the opposite party directly connected with or arising out of the same subject-matter." Id. § 1239, at 711-712; see 1 George E. Palmer, The Law of Restitution § 1.5(a), at 20 (1978) (contrasting lien that "arise[s] out of agreement" from one imposed as a "remedial device, used * * * to enforce a right to restitution"). Accordingly, while various equitable doctrines might serve to limit recovery when enforcement of an equitable lien is sought as a restitutionary remedy, the same is not true when a party seeks enforcement of an equitable lien by agreement. In that setting, traditional equitable principles dictate that the agreement itself controls.

In this case, the lien on respondent's recovery that petitioner seeks to enforce is an equitable lien by agreement. The plan terms, not unjust enrichment principles from the law of restitution that might apply absent an agreement, therefore define the parties' rights and responsibilities. Cf. Restatement (Third) of Restitution and Unjust Enrichment § 2(2), at 15 (2011) ("A valid contract defines the obligations of the parties as to matters within its scope, displacing to that extent any inquiry into unjust enrichment.").

4. Because respondent's obligation is defined by the terms of the plan, not general unjust enrichment principles, his argument for a pro rata reduction of his reimbursement obligation under the plan to reflect his failure to secure complete relief for his accident fails.⁵

In any event, denying respondent the pro rata reduction he seeks would not lead to unjust enrichment or otherwise be inequitable. This Court confronted an analogous situation in *United States* v. *Lorenzetti*, 467 U.S. 167 (1984). That case involved a provision of the Federal Employees' Compensation Act (FECA), 5 U.S.C. 8101 et seq., that imposes a reimbursement obligation on federal employees who receive accident-related compensation payments from the federal government and who later recover for the accident from a

Respondent has abandoned another equitable contention, under which he argued that petitioner could not recover any of the funds it paid for respondent's medical care because his third-party settlement was inadequate to make him whole. See Pet. App. 9a n.2; Br. in Opp. 7 n.1. Even if preserved, that contention would fail for the same reason as his request for a pro rata reduction.

Respondent asserts that the total damages he and his wife suffered came to at least \$1 million, including not only past medical expenses but also "economic damages for past lost wages, future lost wages and loss of earning capacity, and non-economic damages for pain and suffering, embarrassment and humiliation, loss of enjoyment of life, and disfigurement." Br. in Opp. 3-4. "Because [respondent] only recovered 11% of his damages," i.e., \$110,000 as compared with the \$1 million to which he claims he was entitled, he argues that petitioner's "recovery is similarly limited to that same proportion of the medical expenses it paid." Resp. C.A. Br. 26. That would result in petitioner's recovery of only \$7,355.24 of the \$66,866 it paid on respondent's behalf (subject to a further reduction for attorney's fees). Id. at 6. The parties have assumed that the plan's reimbursement provision forecloses such a reduction, so this case does not present any issue of plan interpretation.

third party. See *Lorenzetti*, 467 U.S. at 168. In particular, FECA provides that if the employee "receives money * * in satisfaction of [the third party's] liability as the result of suit or settlement," the beneficiary must "refund to the United States the amount of compensation paid by the United States." *Id.* at 170-171 (quoting 5 U.S.C. 8132); see *id.* at 171 n.2 (noting that the provision also entitles the employee to retain a minimum of one-fifth of the net amount of recovery); see also pp. 28-29, *infra* (discussing Section 8132's allowance for attorney's fees).

The Court in Lorenzetti rejected an employee's argument, like respondent's here, that "the United States' right of reimbursement under § 8132 was confined to recovery out of damages awards or settlements for economic losses of the sort covered by FECA, and that an award or settlement confined to noneconomic losses like pain and suffering was immune from recovery under § 8132." 467 U.S. at 171. That provision, the Court explained, "expressly creates a general right of reimbursement that obtains without regard to whether the employee's third-party recovery includes losses that are excluded from FECA coverage." Id. at 174.

The Court in Lorenzetti noted that in FECA Congress expressed its "intent that federal employees be

⁶ By regulation, a claimant's own insurer is not a third party for FECA purposes. See 20 C.F.R. 10.718. Moreover, FECA considers some apportionment of a recovery to be appropriate to eliminate parts that represent damages to real or personal property, loss of consortium, wrongful death, and survival claims. 20 C.F.R. 10.711(a); see *Lorenzetti*, 467 U.S. at 174 n.3 (agreeing that FECA does not require reimbursement out of third-party compensation for property damage).

treated in a fair and equitable manner," 467 U.S. at 177 (quoting S. Rep. No. 1081, 93d Cong., 2d Sess. 2 (1974)), but the Court nonetheless interpreted FECA's reimbursement provision as precluding an argument analogous to respondent's. The Court acknowledged that "the goal of preventing double recoveries by injured employees does not demand that an employee * * turn over a third-party payment confined to compensation for pain and suffering," but emphasized that enforcement of the statutory provision as written was consistent with the statutory purpose of "minimiz[ing] the cost of the FECA program to the Federal Government." Ibid.

The same analysis applies here. While respondent "himself will be in a better position if the subrogation provision is not enforced, plan fiduciaries must 'take impartial account of the interests of all beneficiaries," and "[r]eimbursement inures to the benefit of all participants and beneficiaries by reducing the total cost of the Plan." Zurich Am. Ins. Co. v. O'Hara, 604 F.3d 1232, 1237-1238 (11th Cir. 2010) (quoting Varity Corp., 516 U.S. at 514), cert. denied, 131 S. Ct. 943 (2011); see Administrative Comm. of Wal-Mart Stores, Inc. v. Shank, 500 F.3d 834, 838 (8th Cir. 2007), cert. denied, 552 U.S. 1275 (2008).

Moreover, the plan's reimbursement provision "confers benefits on both parties." Shank, 500 F.3d at 839. "The purpose of [petitioner's] Plan is to provide coverage for qualified expenses that are not covered by a third party." Pet. App. 4a (emphasis added). Nonetheless, a plan participant "receive[s] the certainty that the [plan] would pay [his] medical bills immediately if [he] was injured," and, in return, the participant pays premiums and "promise[s] to reimburse

the [plan] for medical expenses in the event [he] was injured and received" a third-party recovery. Shank, 500 F.3d at 839. Under these circumstances, even if a court in a suit under Section 502(a)(3) to enforce a lien by agreement could look to general notions of unjust enrichment, enforcement of the plan's reimbursement provision as written creates no unjust enrichment on

the part of the plan.

Finally, application of respondent's pro rata reduction theory to funds recovered in settlements with third parties would create opportunities for manipulation of the amounts apportioned for different categories of damage.7 Under respondent's approach, the more a beneficiary was able to classify a third-party recovery as covering losses other than medical expenses (e.g., non-medical pain and suffering or lost income), the more the beneficiary would be able to keep and the less the plan would receive in reimbursement. Not only would the apportionment percentages be subject to manipulation, but so too would the hypo-

⁷ The Court in Arkansas Department of Health & Human Services v. Ahlborn, 547 U.S. 268 (2006); see Br. in Opp. 2-3, found such manipulation concerns "colorable" but insufficient to trump the plain language of the federal Medicaid statute. See Ahlborn, 547 U.S. at 288. That statute "precludes" a State that paid medical benefits on behalf of a Medicaid beneficiary who was injured in an accident from recovering any portion of the beneficiary's thirdparty settlement designated for categories of damages beyond medical care. See ibid. The Court's holding in Ahlborn "interpret[ed] the language of the Medicaid statute" and "did not divine principles of universal application." Hadden v. United States, 661 F.3d 298, 303 (6th Cir. 2011), petition for cert. pending, No. 11-1197 (filed Mar. 30, 2012); see Shank, 500 F.3d at 839 ("Ahlborn * * turned on the application of the federal Medicaid statute. ERISA, by contrast, does not limit [a plan's] right to reimbursement.").

thetical total losses to the participant, which might bear little or no relation to the amount the plan paid and for which it seeks reimbursement.⁸ Pro rata apportionment could also prove costly and complex to adjudicate. Cf. Kennedy, 555 U.S. at 301 (ERISA values "simple administration") (citation omitted).

B. The Equity Court's Historic Power Over Common Litigation Funds Allows It To Make An Equitable Apportionment Of Fees

As just discussed, Section 502(a)(3) does not authorize a court to revise plan terms based on its own notions of fairness or to invoke general restitutionary unjust enrichment principles, rather than the terms of the plan, to define the parties' obligations to each other when they act in their core roles as provider and receiver of benefits defined by the plan.

When it comes to the costs incurred by the beneficiary in bringing a tort action against a third party, however, different considerations bear on the analysis. In that setting, the terms of the plan do not control the equitable powers of the court to make an equitable apportionment of the costs the beneficiary incurred in the tort action. In the third-party tort litigation that is the predicate to a reimbursement action like this one, the plan participant is acting on behalf of the plan's interests in addition to his own. That litigation is not without considerable cost, which is generally assessed against the beneficiary's recovery in the form

⁸ This manipulation concern would be mitigated if the apportionment of damage categories or assessment of total damages was done by court judgment, rather than in an unsupervised settlement—at least if the plan was given an opportunity to participate or approve the apportionment.

of attorney's fees (and associated litigation costs). And the plan knowingly accepts a valuable benefit from its beneficiary when the plan declines to act on its own behalf by bringing a subrogation action directly against other liable parties or by participating in the beneficiary's suit.

Under those narrow circumstances, in which the predicate third-party action places plan and beneficiary in a special relationship that is well-recognized in equity litigation, the equity court's inherent authority to take account of that relationship comes to the fore. In particular, the court may draw on the longstanding equitable common-fund doctrine to require the plan to make an equitable contribution to the beneficiary for the expenses the beneficiary incurred for the services of the attorneys who secured them a common benefit.⁹

Previously, in Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough, PC, 354 F.3d 348 (5th Cir. 2003), cert. denied, 541 U.S. 1072 (2004), the Secretary of Labor had filed an amicus brief in which she argued that where plan terms expressly provide for full reimbursement and expressly disclaim responsibility for attorney's fees and costs, courts should

In Sereboff, the government argued that "nothing in ERISA prohibits a plan sponsor from adopting plan terms that require full reimbursement for payment of medical expenses, and ERISA's goal of minimizing the costs to employers of providing welfare benefits would be furthered by allowing it to do so." No. 05-260 Gov't Br. at 29. In that case, however, "the plan * * * paid its share of attorney's fees, and neither party * * sought review of that issue." Id. at 29 n.14. Accordingly, the government noted that "[t]he Court * * ha[d] no occasion to consider whether a plan in a reimbursement action should be charged a proportionate share of the attorney's fees a participant or beneficiary incurs in obtaining a third-party recovery," and the government did not address that question. Ibid.

1. "The common-fund doctrine reflects the traditional practice in courts of equity." Boeing Co. v. Van Gemert, 444 U.S. 472, 478 (1980); see Sprague v. Ticonic Nat'l Bank, 307 U.S. 161, 166 (1939) ("[T]he foundation for the historic practice of granting reimbursement for the costs of litigation other than the conventional taxable costs is part of the original authority of the chancellor to do equity in a particular situation."). This Court thus "has recognized consistently that a litigant or a lawyer who recovers a common fund for the benefit of persons other than himself or his client is entitled to a reasonable attorney's fee from the fund as a whole." Boeing Co., 444 U.S. at 478.

The Court initially applied the common-fund doctrine in an equity suit by a holder of bonds secured by property held in trust. See *Trustees* v. *Greenough*, 105 U.S. 527 (1882). The bondholder, "at great expense and trouble," established that the trustees were fraudulently selling the property and obtained both an injunction against additional sales and appointment of a receiver to recover property already sold. See *id.* at 528-529, 532. The bondholder thereby obtained properties in trust for the benefit of other bondholders who had not participated in the litigation but who re-

enforce the plan's plain terms and should not apply the commonfund doctrine. See *Bombardier* C.A. Br. of Amicus Curiae Elaine L. Chao, Secretary of Labor, at 17-21, available at http://www.dol.gov/sol/media/briefs/bombardier-9-11-03.pdf. Upon further reflection, and in light of this Court's discussion of ERISA's preservation of the equity court's core remedial powers in *Amara*, 131 S. Ct. at 1879-1880 (discussing remedies of contract reformation and surcharge), the Secretary is now of the view that the commonfund doctrine is generally applicable in reimbursement suits under Section 502(a)(3).

ceived a valuable benefit thanks to his work. See id. at 529.

Under these circumstances, the bondholder, although not formally a trustee, "ha[d] at least acted the part of a trustee in relation to the common interest." Greenough, 105 U.S. at 532. Because he "worked for [the absent bondholders] as well as for himself," the Court held that "if he cannot be reimbursed out of the fund itself, [the absent bondholders] ought to contribute their due proportion of the expenses which he has fairly incurred." Ibid. The Court grounded this contribution obligation in the "general principle that a trust estate must bear the expenses of its administration." Ibid.

The Court in *Greenough* recognized that Congress in 1853 had enacted a statute governing payment of court fees that "appear[ed] to be intended to cover the whole ground of taxation of costs at law and in equity." 105 U.S. at 535 (citing Act of Feb. 26, 1853, ch. 80, 10 Stat. 161). The Court, however, found that statute insufficient to answer the question before it because the statute "contain[ed] nothing which can be fairly construed to deprive the Court of Chancery of its longestablished control over the costs and charges of the litigation, to be exercised as equity and justice may require, including proper allowances to those who have instituted proceedings for the benefit of a general fund." Id. at 536; see id. at 535 (referring to the historic "power of a court of equity, in cases of administration of funds under its control, to make such allowance to the parties out of the fund as justice and equity may require").

In the 130 years since *Greenough*, the Court has applied the equitable common-fund doctrine in a vari-

ety of settings to allocate attorney's fees between litigating parties (and their attorneys) and absent parties. See, e.g., Central R.R. & Banking Co. v. Pettus, 113 U.S. 116, 124-127 (1885) (applying doctrine to require equitable allocation of fees incurred in litigation that "was intended to be, and throughout was, conducted as a suit for the benefit, not exclusively of the complainants, but of the class to which they belonged," and was "so regarded by all connected with the litigation"); Sprague, 307 U.S. at 164 ("Allowance of such costs in appropriate situations is part of the historic equity jurisdiction of the federal courts."); Mills v. Electric Auto-Lite Co., 396 U.S. 375, 389-391 (1970) (applying doctrine to require apportionment of attorney's fees for stockholders who established that their corporation violated securities laws); Hall v. Cole, 412 U.S. 1, 5-8 (1973) (citing common-fund doctrine as support for award of attorney's fees under Labor-Management Reporting and Disclosure Act of 1959 (LMRDA), 29 U.S.C. 412, where plaintiff "rendered a substantial service to his union as an institution and to all of its members"); Boeing, 444 U.S. at 479-482 (relying on the "well-recognized" commonfund doctrine to allow assessment of attorney's fees against unclaimed portion of fund created by a judgment); see also United States v. Equitable Trust Co., 283 U.S. 738, 744 & n.7 (1931); Harrison v. Perea, 168 U.S. 311, 325-326 (1897); Dodge v. Tulleys, 144 U.S. 451, 456-458 (1892).

In particular, courts have long applied the commonfund doctrine to insurance reimbursement cases like this one, reducing the insurer's recovery amount by a proportionate share of the participant's litigation expenses when the participant has secured a valuable benefit for both himself and the insurer. See Johnny Parker, The Common Fund Doctrine: Coming of Age in the Law of Insurance Subrogation, 31 Ind. L. Rev. 313, 329-337 (1998); see also Annot., Right of Attorney for Holder of Property Insurance to Fee out of Insurance Share of Recovery from Tortfeasors, 2 A.L.R. 3d 1441, §§ 2-3 (1965 & Supp. 2012) (contrasting numerous cases in which courts required insurer to pay a fee to the insured's attorney with "a very few cases" in which courts declined to do so); 16 Lee R. Russ & Thomas F. Segalla, Couch on Insurance 3d § 223:113 (2000).

2. A court entertaining a request for "appropriate equitable relief" under Section 502(a)(3) to enforce a plan's reimbursement provision should apply the common-fund doctrine to equitably apportion attorney's fees. This result flows not from any free-floating power to apply unjust enrichment or other equitable principles to reduce the recovery in a suit to enforce the reimbursement provision in a plan, but instead from the relationship between the parties and the common-fund nature of the monies at issue.

As noted above, the parties' core relationship involving benefits, and the conditions attaching to them, is properly defined by the plan, not unjust enrichment principles. But the longstanding powers of the court in equity should come into play when the question shifts away from the scope of benefits and terms of the plan to the costs of litigation when a participant or beneficiary has conducted the litigation and the plan has benefited. As the above discussion of the common-fund doctrine demonstrates, that is a question that equity has long decided, and it is qualitatively different than the scope of benefits offered under an

ERISA plan. Accordingly, a court entertaining a request for "appropriate equitable relief" to enforce a reimbursement obligation should do so according to the terms of the plan, but should also apply commonfund principles to require an equitable apportionment of attorney's fees.¹⁰

This equitable power should be undisturbed even if the plan purports to limit it. Cf. Dodge, 144 U.S. 456-457 (applying common-fund doctrine to award attorney's fees even though only trust provision allowing such fees was nullified by state law). The common-fund doctrine is rooted in the equity court's own "long-established control over the costs and charges of the litigation." Greenough, 105 U.S. 536. There is no indication in ERISA that the statute was intended to authorize an ERISA plan to override that deeply rooted power of a court exercising its authority to grant "appropriate equitable relief." See Hall, 412 U.S. at 10 (LMRDA's grant of power to award "appropriate" relief does not "deny to the courts the traditional equitable power to grant counsel fees in 'appropriate' situations"); Mills, 396 U.S. at 391 (Securities Exchange Act of 1934 did not "circumscribe the courts' power to grant appropriate remedies" including to award attorney's fees under common-fund doctrine); Greenough, 105 U.S. at 535 (stat-

¹⁰ Respondent is not necessarily entitled to a mechanical, pro rata apportionment of his attorney's 40% contingency fee. Instead, the district court on remand would have authority to make an equitable allocation and ensure that any fees that would reduce respondent's reimbursement obligation are reasonable. See Pet. App. 17a; see also *Pettus*, 113 U.S. at 128 (reviewing fee awarded under common-fund doctrine for reasonableness).

ute authorizing court costs does not "take away the power of a court of equity to permit counsel fees"); see also *Dodge*, 144 U.S. at 457 (state statute prohibiting courts of equity from awarding attorney's fees would not constrain federal court). Thus, a court's inherent power may not be nullified by an ERISA plan term, just as an ERISA plan could not nullify an equity court's power under Section 502(a)(3) to issue an injunction, "reform contracts" to prevent fraud, or impose a "surcharge remedy" to remedy an ERISA fiduciary's breach of trust. *Amara*, 131 S. Ct. at 1879-1880.

- 3. Some federal insurance and worker's compensation schemes include provisions requiring beneficiaries to make reimbursement payments when they recover from a third party for an accident that leads to covered expenses. Each scheme has a different statutory basis, and none is like ERISA in making reimbursement obligations enforceable only through an action for "appropriate equitable relief." 29 U.S.C. 1132(a)(3). Accordingly, the power of a court in equity to apply the common-fund doctrine and make an equitable allocation of attorney's fees is immaterial in actions brought under those statutes. Nonetheless, in some of those settings, Congress or an implementing agency has expressly limited the reimbursement obligation to account for attorney's fees.
- a. As discussed above, FECA requires reimbursement to the government when a federal employee "receives money * * * in satisfaction" of a third party's liability for an accident that led to covered expenses, even if that recovery is denominated as for pain and suffering. Lorenzetti, 467 U.S. at 170-171 (quoting 5 U.S.C. 8132); see pp. 17-18, supra. FECA

expressly provides, however, that the extent of the employee's reimbursement obligation is measured "after deducting therefrom the costs of suit and a reasonable attorney's fee," *Lorenzetti*, 467 U.S. at 170-171 (quoting 5 U.S.C. 8132), and that the employee is entitled to retain "a reasonable attorney's fee proportionate to the refund to the United States," 5 U.S.C. 8132. See 20 C.F.R. 10.712.

b. The Medicare Secondary Payer (MSP) provisions reduce Medicare's costs by making Medicare secondary to other insurance coverage or payments by a third-party tortfeasor. Under the MSP provisions, payments that Medicare makes on a beneficiary's behalf are conditional and must be reimbursed if the beneficiary receives payment with respect to the same items or services from another party. See 42 U.S.C. 1395yb(2)(B)(ii). In implementing the MSP provisions, the Department of Health and Human Services (HHS) has expressly provided by regulation that it will reduce a participant's reimbursement obligation by an allowance for the costs of procuring the judgment or settlement. See 42 C.F.R. 411.37(c).¹¹

¹¹ HHS has also interpreted its regulations to provide that where a beneficiary's suit against a tortfeasor results in a "court order on the merits of the case" that awards one amount for medical expenses and a separate amount for other losses, Medicare will limit its claim for reimbursement to the amount designated for medical expenses. See MSP Manual, ch. 7, § 50.4.4 (2003). If, however, the beneficiary receives a settlement that resolves both medical-expense claims and other claims, such as pain and suffering, HHS interprets its regulations to require full reimbursement out of the settlement. See *ibid.*; see also Hadden, supra, n.7, 661 F.3d at 302-304, (agreeing with HHS's interpretation and rejecting Medicare beneficiary's argument that his reimbursement obligation

c. Under the Longshore and Harbor Workers' Compensation Act (Longshore Act), 33 U.S.C. 901 et seq., longshore workers receive compensation payments from their employers when they suffer a disability or death resulting from an injury on navigable waters. See Bloomer v. Liberty Mut. Ins. Co., 445 U.S. 74, 74 (1980). A worker may also sue the owner of the ship where the injury occurred for negligence, but any recovery is subject to a lien totaling the amount of longshore compensation paid by his employer. See id. at 75.

In Bloomer, a longshore worker from whom an employer sought full reimbursement for benefits it had provided after he recovered from a ship owner contended "that the common-fund doctrine should be available to permit the employee to recover from the [employer] a proportionate share of the expenses of suit." 445 U.S. at 85. The Court rejected that argument, finding that Congress had supplanted the common-fund doctrine in the Longshore Act's remedial scheme. See id. at 85-88. The Court noted, however, that the case before it did not present circumstances under which "the recovery against the shipowner [was] less than the sum of the lien and the expenses of suit," such that complete enforcement of the employer's lien would result in a net loss for the worker. See id. at 86 n.13.

Four years after *Bloomer*, Congress amended the Longshore Act to expressly foreclose the net-loss scenario referred to by the Court. See Longshore and Harbor Workers' Compensation Act Amendments of 1984, Pub. L. No. 98-426, § 21, 98 Stat. 1652 (amend-

should be subject to pro rata deduction because he recovered only 10% of his damages in tort settlement).

ing 33 U.S.C. 933(f)). The amendment provided that if a compensated employee brings a timely negligence action and recovers, the employer will be entitled to reimbursement to the extent its compensation payments do not exceed the employee's "net amount recovered." See ibid. The amendment further specified that "[s]uch net amount shall be equal to the actual amount recovered less the expenses reasonably incurred by such person in respect to such proceedings (including reasonable attorneys' fees)." Ibid. conference committee explained that this amendment was intended to give first priority to "litigation expenses, including reasonable attorney fees," but that "It he compensation lien on the net recovery remains inviolable, consistent with Bloomer." H.R. Rep. No. 1027, 98th Cong., 2d Sess. 36 (1984) (emphasis added).

d. The Federal Employees Health Benefits Act of 1959 (FEHBA), 5 U.S.C. 8901 et seq., establishes a comprehensive program of health insurance for federal employees. The Act authorizes the Office of Personnel Management (OPM) to contract with private carriers to offer employees an array of health care

plans. See 5 U.S.C. 8902(a) (Supp. IV 2010).

FEHBA does not include a provision governing the reimbursement rights of carriers, but OPM contracts include provisions governing reimbursement. See *Empire Healthchoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 685 (2006) (noting that all reimbursements obtained by the carrier under such reimbursement provisions are refunded directly to the Treasury). For example, the contract between OPM and the Blue Cross Blue Shield Service Benefits Plan (Blue Cross) obligates the carrier to make "a reasonable effort" to recoup amounts paid for medical care. *Id.* at 683.

Blue Cross's statement of benefits alerts enrollees that "[i]f another person or entity, through an act or omission, causes [enrollees] to suffer an injury or illness, and if [Blue Cross] paid benefits for that injury or illness," the enrollees are subject to a reimbursement obligation. 2012 Blue Cross Plan Brochure at 125 (Plan Brochure), http://www.opm.gov/insure/health/planinfo/2012/brochures/71-005.pdf. It also states that "[a]ll recoveries" enrollees "obtain (whether by lawsuit, settlement, or otherwise), no matter how described or designated, must be used to reimburse [Blue Cross] in full for benefits [it] paid." *Ibid*.

Blue Cross's FEHBA statement of benefits also expressly addresses attorney's fees. It states that the plan is "entitled under our right of recovery to be reimbursed for our benefit payments even if you are not 'made whole' for all of your damages in the recoveries that you receive"; that the plan's right of recovery is "not subject to reduction for attorney's fees and costs under the 'common fund' or any other doctrine"; and that the plan "will not reduce our share of any recovery unless, in the exercise of our discretion, we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees." Plan Brochure at 125.

Those contract provisions negating any judicially imposed common-fund apportionment of attorney's fees are valid and enforceable in the context of FEHBA, which does not include an "appropriate equitable relief" remedial provision. In a breach-of-contract action, like those brought by FEHBA carriers to enforce their policies' reimbursement provisions, normal contract rules in an action at law apply,

and the historic powers of the court in equity (including the power to apply the common-fund doctrine) are not at issue.¹²

¹² The Court in McVeigh held that there was no federal jurisdiction over reimbursement suits by FEHBA carriers to enforce such reimbursement provisions. See 547 U.S. at 683. In a recent letter to FEHBA carriers, OPM emphasized that, no matter where such reimbursement actions are brought, "FEHB Program contracts and the applicable statement of benefits (brochures) require enrollees to reimburse the plan in the event of a third party recovery" and that "[c]arriers are required to seek reimbursement and/or subrogation recoveries in accordance with the contract." OPM Letter No. 2012-18, at 1 (June 18, 2012). The letter also advises that state laws limiting FEHBA carriers' subrogation and reimbursement rights are preempted by federal law. See id. at 1-2; see also 5 U.S.C. 8902(m)(1) (FEHBA preemption provision); McVeigh, 547 U.S. at 697-698 (discussing one "plausible construction[]" of FEHBA preemption provision under which it would preempt state laws limiting subrogation and reimbursement, but finding it unnecessary to decide that question).

CONCLUSION

The judgment of the court of appeals should be affirmed to the extent it remands for application of the common-fund doctrine, but reversed to the extent it remands for application of other equitable theories that would limit respondent's reimbursement obligation to the plan.

Respectfully submitted.

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APPENDIX

29 U.S.C. 1132(a) provides:

Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought-

- (1) by a participant or beneficiary-
- (A) for the relief provided for in subsection (c) of this section, or
- (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
- (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;
- (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;
- (4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;
- (5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable

- relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;
- (6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6), (7), (8), or (9) of subsection (c) of this section or under subsection (i) or (l) of this section;
- (7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);
- (8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection;
- (9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts; or

¹ So in original. Probably should be "subtitle".

- (10) in the case of a multiemployer plan that has been certified by the actuary to be in endangered or critical status under section 1085 of this title, if the plan sponsor-
 - (A) has not adopted a funding improvement or rehabilitation plan under that section by the deadline established in such section, or
 - (B) fails to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section,

by an employer that has an obligation to contribute with respect to the multiemployer plan or an employee organization that represents active participants in the multiemployer plan, for an order compelling the plan sponsor to adopt a funding improvement or rehabilitation plan or to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section and the funding improvement or rehabilitation plan.

AMICUS CURIAE BRIEF

No. 11-1285

OCT 2 5 2012 OFFICE OF THE CUTS

In The Supreme Court of the United States

U.S. AIRWAYS, INC., IN ITS CAPACITY AS FIDUCIARY AND PLAN ADMINISTRATOR OF THE U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN,

Petitioner,

V.

JAMES E. MCCUTCHEN, ET AL., Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF AMICI CURIAE AARP AND NATIONAL EMPLOYMENT LAWYERS ASSOCIATION IN SUPPORT OF RESPONDENTS

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INTERESTS OF AMICI CURIAE1

AARP is a non-partisan, non-profit organization dedicated to representing the needs and interests of people age fifty and older. Nearly one-third of AARP's members are currently employed with many working for employers which provide pension and health plans covered by the Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1001. Many other members are retired and receiving or have received retirement benefits from those employers.

One of AARP's primary objectives is to foster the economic security of individuals as they age by attempting to ensure the availability, security, equity, and adequacy of public and private pension, health, disability, and other employee benefits through educational and advocacy efforts. private, employer-sponsored Participants in employee benefit plans rely on ERISA to protect their rights under those plans. See Title I -Protection of Employee Benefit Rights, 29 U.S.C. §§ 1001-1191(c). In particular, ERISA's

Pursuant to Supreme Court Rule 37, counsel of record received notice timely notice of the intent to file this brief and, on behalf of the parties, have consented to the filing of this brief. No counsel for a party authored this brief, in whole or in part; and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No party other than amicus or its counsel made a monetary contribution to its preparation or submission. Letters from the parties consenting to the filing of amicus briefs have been filed with the Clerk of the Court.

protections, and plan participants' opportunities to enforce the statute's protections, are of vital concern to workers of all ages and to retirees, since the quality of their lives depends heavily on their eligibility for and the amount of their retirement and welfare benefits. Indeed, since ERISA has been enacted, the Court has granted certiorari on numerous cases concerning the framework of ERISA's civil enforcement provisions, all of which have been crucial to the rights of participants and beneficiaries under ERISA.

The National Employment Lawyers Association (NELA) advances employee rights and serves lawyers who advocate for equality and justice in the American workplace. With 68 circuit, state and local affiliates, and 3,000 members across the country, NELA is the nation's largest professional organization composed exclusively of lawyers who represent individual employees in cases involving employment discrimination, wrongful termination, employee benefits, and other employment-related matters.²

² AARP and NELA have, jointly and singly, participated as amicus curiae in this Court to protect the rights of workers and their beneficiaries under ERISA. See, e.g., CIGNA Corp. v. Amara, 131 S.Ct. 1866 (2011); Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356 (2006); Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002); Varity Corp. v. Howe, 516 U.S. 489 (1996); Mertens v. Hewitt Assocs., 508 U.S. 248 (1993); Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989).

Resolution of the issues in this case will have a direct and vital bearing on employee benefit plan participants' ability to make informed decisions concerning their benefits and whether they should take any action, at all, to sue third party tortfeasors where they may receive little or no recovery for themselves or, worse, as here, wind up owing the plan more than they receive from the tort case.³ Consequently, AARP and NELA respectfully submit this brief amici curiae to facilitate a full consideration by the Court of the important issues presented.

SUMMARY OF ARGUMENT

A review of past Supreme Court ERISA decisions shows that the argument of Petitioner and its amici, that unless the Court adopts the precise position for which they are arguing, the sky will fall, and employee benefit plans as we know them will cease to exist, is exaggerated and should be rejected. Indeed, Petitioners and its amici provided no current and comprehensive evidence to the Court showing that reimbursement recoveries are at all significant. Moreover, these recoveries are not consequential enough to have any meaningful effect on rate setting

³ It is not uncommon that after payment of attorneys' fees and expenses, the participant's recovery is less than the amount of medical benefits paid. See, e.g., FMC Corp. v. Holliday, 885 F.2d 79, 80 (3d Cir. 1989), vacated and remanded, 498 U.S. 52 (1990); Admin. Comm. of the Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Shank, 500 F.3d 834, 835 (8th Cir. 2007); U.S. Airways, Inc. v. McCutchen, 2010 U.S. Dist. LEXIS 89377, *2-3 (W.D. Pa. 2010).

or the trend of rising health care costs. Finally, not only is there no evidence of the underlying assumption of Petitioner and its amici that they will obtain more money if they insist on 100% reimbursement, but common sense suggests that participants are more likely to bring fewer lawsuits when they know they may have to pay money out of pocket, resulting in less money for the plans.

ARGUMENT

I. PETITIONER'S AMICI'S ARGUMENT THAT THE "SKY IS FALLING" IS HYPERBOLIC AND UNPERSUASIVE.

It has become a tradition for plans and amici supporting the plans to raise certain arguments in ERISA cases before this Court. They describe in exquisite detail the purported domino effect that any decision, except the exact one for which they are advocating, will have on employee benefit plans. Thus, the Court has heard ERISA plans contend the following: plans need near perfect uniformity in order to function; if the plan provisions interpreted by plan fiduciaries do not control in all cases, plans will lack necessary predictability; and if the decisions of plan administrators are subject to challenge, plans will become more expensive due to increased litigation costs. The result if these occur, according to these plans and amici, will be that employers will cut benefits or refuse to offer plans altogether. See, e.g., Brief for Petitioner, Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008) (No. 06-856), 2008 U.S. S. Ct. Briefs Lexis 258, at *51 (Feb. 25,

2008) ("Increasing the litigation burdens on ERISA plans will drain their limited financial resources and discourage employers from establishing benefit plans to the substantial detriment of existing and prospective plan participants and beneficiaries."); Brief for America's Health Insurance Plans et al. as Amici Curiae Supporting Petitioner, Glenn, 554 U.S. 105, 2008 U.S. S.Ct. Briefs Lexis 290, *27-28 (Mar. 3, 2008) ("Employers might respond to those costs in various ways - by reducing the available coverage. paving increased premiums, or discontinuing the plan entirely - but none of them would redound to the benefit of plan participants in the long run.); Brief for The ERISA Industry Committee as Amicus Curiae Supporting Respondents, LaRue v. DeWolff, Boberg & Assoc. Inc., 552 U.S. 248 (2008) (No. 06-856), 2007 U.S. S.Ct. Briefs Lexis 729, at *15-16 (Sept. 11, 2007) ("Plans will suffer financially under of mounting litigation burden necessitating reductions in benefits, increases in required employee contributions, or both. employer interest in sponsoring employee benefit plans will decline."); Brief for Chamber of Commerce as Amicus Curiae Supporting Petitioners, Varity Corp. v. Howe, 516 U.S. 489 (1996) (No. 94-1471), 1995 U.S. S. Ct. Briefs Lexis 347, at *6 (June 23, 1995) (Plans "would be forced to defend and pay recoveries under these additional claims, thereby increasing the overall cost of benefit administration and offsetting private sector efforts to manage health care spending").

Nevertheless, in each of the cases cited above, the Court has reached a decision contrary to that

urged by plans and amici. In fact, in some of those cases, the Court has specifically rejected those arguments either because the arguments had no support, see Glenn, 554 U.S. at 113 (rejecting MetLife's argument because "we have no reason. empirical or otherwise, to believe that our decision will seriously discourage the creation of benefit plans"), or because they constituted a strained reading of the statute and ignored the balance that Congress attempted to achieve. See Varity Corp., 516 U.S. at 513-515. Petitioner and its amici here present no evidence that the sky has fallen as a result of the Court's decisions in these cases. Likewise, here, there will be no falling skies if the Plan's reimbursement rights are limited by the centuries' old and firmly entrenched equitable principles of "common fund" and "no double recovery."

- II. THE INSIGNIFICANCE OF REIMBURSEMENT RECOVERIES IN THE RATE SETTING PROCESS CONTRADICTS THE ARGUMENT THAT FULL REIMBURSEMENT IS VITAL TO PLAN STABILITY.
 - A. Petitioner's Amici's Failure To Provide Any Recent and Complete Evidence Of The Amounts Of Reimbursement Recoveries Suggests That They Are Inconsequential.

"The health insurance company financial data that could most directly demonstrate specific plan level medical and administrative expenses that drive premiums generally is propriety and confidential." Mark Newsom & Bernadette Fernandez, Cong. Research Serv. R41588, Private Health Insurance Premiums and Rate Reviews 3, n.10 (2011), available http://assets.opencrs.com/rpts/R41588_20110111 .pdf. Despite their claims. Petitioner and its amici provided comprehensive current information demonstrating the purported correlation between reimbursement recoveries and rate setting for health plans, even though they are the ones in control of this information. Although amici volunteer a limited amount of outdated incomplete data - after it has been cherry-picked by them, this evidence in fact does not support their arguments.4 See Brief for Blue Cross Blue Shield

 $^{^4}$ If the amounts cited as recovered are gross amounts, plans will in fact receive less after collection expenses. E.g.,

Ass'n et al. as Amici Curiae Supporting Petitioner at 12, U.S. Airways, Inc. v. McCutchen, No. 11-1285 (U.S. Sept. 5, 2012), citing Brief for America's Health Ins. Plans, Inc. et al. as Amici Curiae Supporting Respondent, Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356 (2006) (No. 05-260), 2006 WL 460877, at *3 n.3 (Feb. 23, 2006) (using estimated statistics from 2003); Motion of the Am. Ass'n of Health Plans et al. For Leave to File a Brief as Amici Curiae and Brief as Amici Curiae Supporting Petitioners, Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002) (No. 99-1786), 2001 WL 487681 at *10, n.20 (May 2, 2001) (using data from the year 2000). Instead, it demonstrates that the impact of these recoveries on each plan is miniscule.

The citation to American Health Insurance Plans' brief in Sereboff by amici Blue Cross Blue Shield and Rawlings sheds no light on the amount and impact of reimbursement recoveries on plans. That citation estimated that in 2003, plans recovered in excess of \$1 billion through reimbursement provisions. See Brief for Blue Cross Blue Shield Ass'n et al. as Amici Curiae Supporting Petitioner, at 12, McCutchen, No. 11-1285, citing Brief for America's Health Ins. Plans, Inc. et al. as Amicus Curiae Supporting Respondent, Sereboff, 547 U.S. 356, 2006 WL 460877, at *3, n.3. Amici does not provide a comparison to the total amount of health expenditures paid during that same year for the

Sedgwick Claims Management Services, Central Subrogation (2012), available at https://www.sedgwickcms.com/services/docs/SubrogationOverview.pdf. (collection expense ranges between 15-40% of the recoveries obtained).

same plans, which would provide an indication of the percentage of recovery for the plan or a comparison to the total number of covered lives, which would provide an indication of the impact on each participant. However, further analysis of the underlying report reveals that approximately \$300 billion is paid in premiums to those plans, resulting in reimbursement recoveries of merely one-third of 1 percent of premiums. See Barents Group, Impacts of Four Legislative Provisions on Managed Care Consumers: 1999-2003 (1998).

Another exemplar cited by amici Blue Cross Blue Shield and Rawlings was the recovery of \$237.3 million by one of the United States' "largest private health care claims recovery services." See Brief for Blue Cross Blue Shield Ass'n et al. as Amici Curiae Supporting Petitioner, at 12, n. 9, McCutchen, No. 11-1285, citing Motion of the Am. Ass'n of Health Plans et al. For Leave to File a Brief as Amici Curiae and Brief as Amici Curiae Supporting Petitioners, Knudson, 534 U.S. 204, 2001 WL 487681 at *10 n.20 (emphasis added). However, on closer inspection

⁵ Amici AARP and NELA note that at least a portion of this recovery is due to overpayments or mistaken payments. We urge the Court not to expand its decision to such disputes because they tend to be extremely very fact-intensive, ranging for example from participant fraud on the plan, Trustees of the AFTRA Health Fund v. Biondi, 303 F.3d 765 (7th Cir. 2002) (keeping ex-spouse on health plan in violation of plan eligibility rules), to a plan's mistaken approval for health procedures that was relied upon to the participant's detriment, cf. Kenseth v. Dean Health Plan, Inc., 610 F.3d 452 (7th Cir. 2010) (after approval for gastric bypass surgery, participant underwent surgery and plan refused to pay).

this recovery amount was for 52,500,000 covered lives, or \$4.52 per person per year or \$0.38 per person per month. See Healthcare Recoveries, Inc., Form 10-K, for the fiscal year ended Dec. 31, 2000, at 22, http://www.sec.gov/Archives/edgar/data/858 629/000095014401004044/g67733e10-k405.txt.

Amicus Central States provides more recent data, but it also does not support the other amici's arguments that reimbursement recoveries significant to the financial viability of its plan. Comparing the average 240,000 participants in the Central States Health Plan⁶ with the cited average recoveries of \$5.7 million per year during the period of 2002-2011. Brief for Central States as Amicus Curiae Supporting Petitioner at 1, 3, McCutchen, No. 11-1285 (U.S. Sept. 5, 2012), results in an average recovery per person annually of \$21.13, or \$1.76 per Central States pays roughly \$1 person monthly. billion in benefits annually. Central States Funds, supra note 6. Therefore, on average, for this plan, subrogation and reimbursement recoveries represent a mere one-half of one percent (about .57%) of benefits paid.

No matter how one looks at reimbursement recovery amounts, they are insignificant in relation both to the total benefits paid as well as when viewed on a per capita basis.

⁶ See Central States Funds, About Central States Funds, https://www.centralstatesfunds.org/CSF/plans/ourcompany.asp x (last visited Oct. 18, 2012) (Central States' website stating it covers approximately 250,000 participants)

B. Amounts Recovered Through Reimbursements Are So Insignificant That Actuaries Do Not Afford Them Their Own Category In Rate Setting.

Actuaries use mathematics, statistics and financial theory to evaluate how risk uncertainty will affect financial costs. By analyzing the likelihood an event will occur, they aid entities like insurance companies and employee benefit plans in minimizing the cost of risk. Bureau of Labor Statistics, U.S. Dep't of Labor, Occupational Outlook Handbook, 2012-13 Edition, Actuaries, available at http://www.bls.gov/ooh/math/actuaries.htm visited October 18, 2012). Actuaries review historical statistics showing how likely it is that a claim will be made by a insured, how much the entity will have to pay in claims, and how much the entity will need to charge to pay these claims and make a profit, without being at odds with the marketplace. significant Reimbursement recoveries are not enough to merit their own category during the rate See generally Mark Newsom & setting process. Bernadette Fernandez, Cong. Research Serv., R41588. Private Health Insurance Premiums and Reviews Summary (2011), available Ratehttp://assets.opencrs.com/rpts/R41588_20110111.pdf (reimbursement recoveries are not a Coverage, AHIP How Are Health Insurance Premiums Determined (Sept. 8, 2010), http://www.ahipcoverage.com/wp-content/uploads/20 10/09/The-Hay-Group-How-Health-Insurance-Premi ums-Are-Determined.pdf (rate setting is based on

actuarial calculations, but reimbursement recoveries are not a separate category).

Because reimbursement recoveries are such a miniscule amount, it merits no particular attention from actuaries.

C. Rising Health Care Costs Are A
Serious Concern, But No One Has
Suggested That Increasing
Reimbursement Recoveries Will
Have Any Effect On This Trend.

An underlying theme discussed in this case is rising health care costs. However, not only do actuaries not account for reimbursement recoveries as a separate category in rate setting, but among the thousands of studies, papers, articles, and editorials written on reining on the increase in health care costs, regardless of their authors' philosophical or political leanings, none could be found that suggests that increasing. or holding the line on. reimbursement amounts from third-party tort recoveries had or would have any significance in breaking the increases. E.g. Politico Pro, AHIP's Ignagni Addresses Drivers of Health Care Costs (Oct. http://www.ahipcoverage.com/2012 10. 2012). /10/10/politico-pro-ahips-ignagni-addresses-drivers-of -health-care-costs/ (focusing on insurance premium tax, age rating and essential health benefits); Issues: Healthcare. U.S. Chamber of Commerce. http://www.uschamber.com/issues/health/health-care -archives (last visited Oct. 20, 2012) (suggesting among numerous factors that will lower health care

costs, enacting meaningful medical liability reform, reining in fraud and abuse, realigning incentives to award quality not quantity); Comm. on the Learning Health Care System in America, Best Care at Lower Cost: The Path to Continuously Learning Health Care in America (Mark Smith et al. eds., 2012), available at http://iom.edu/Reports/2012/Best-Care-a t-Lower-Cost-The-Path-to-Continuously-Learning-H ealth-Care-in-America.aspx (focusing factors); Robert A. Berenson, Paul B. Ginsburg, Jon B. Christianson & Tracy Yee, The Growing Power Of Some Providers To Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed, 31 Health Aff. No. 5 at 973-981 (May 2012), available at http://content.healthaffairs.org/content /31/5/973.full?keytype=ref&siteid=healthaff&ijkey= %2F16n5ximN8506 (focusing on provider costs); Bipartisan Policy Ctr., What is Driving U.S. Health Care Spending? America's Unsustainable Health Care Cost Growth 6-7 (2012) (providing a laundry factors). available of list athttp:// bipartisanpolicy.org/sites/default/files/BPC %20Health%20Care%20Cost%20Drivers%20 Brief%20Sept%202012.pdf; Kaiser Found., What is driving health care spending?, U.S. Health Care Costs. Background Brief. http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx, What is driving health care spending? (last visited Oct. 19, 2012) (same); United Health Grp., Why Are Health Care Rising? 2010). (March available http://www.unitedhealthgroup.com/hrm/UNH-Healt h-Care-Costs.pdf (focusing on hospital and physician payment rate increases); Jason Fodeman, M.D. &

Robert A. Book, Ph.D., "Bending the Curve": What Really Drives Health Care Spending (Feb. 17, 2010), available at http://www.heritage.org/research/reports/2010/02/bending-the-curve-what-really-drives-health-care-spending (pricing system provides wrong incentives to patients and providers); Dustin Chambers, What is Driving Rising Healthcare Costs?, The American (May 18, 2009), available at http://www.american.com/archive/2009/may-2009/What-is-driving-rising-healthcare-costs (insurance-based payment system, low labor-productivity growth, and constrained supply of healthcare providers).

None of these organizations lists the failure to obtain total reimbursements of medical costs where third party tortfeasors have caused the injury to the insured as a method of ameliorating the increase in health care costs. The reason for this conspicuous silence is simple: such recoveries have minimal, if any, impact and, quite literally, are not worth mentioning.

D. The Plan's Argument Here Is Contrary To Common Sense And The Self-Interest Of Plans More Broadly.

The position of Petitioners and its amici that a plan's reimbursement cannot, and should not, be limited by the centuries' old concepts of "common fund" and "no double recovery" is at odds with common sense and plans' self-interest. Potential plaintiffs will be less likely to go to court to attempt

to vindicate their rights against a third party tortfeasor if they end up worse off than before they sued, having to pay money out of their pockets back to their health plans. Amici here doubt that Mr. McCutchen would have pursued his claim if he had been made aware of the result urged by the Plan here. There will be no incentive for participants to bring suits to recover from third party tortfeasors where there is the chance for little or no gain, or if there is a chance that the participant will, in fact, have to pay money out of pocket to pay the plan's share of attorneys' fees and costs. It is these circumstances that will have a much greater effect on the plans than the failure to recover the entirety of what plans pay out to beneficiaries injured by third parties.

The plan and its amici have not proffered any evidence that demonstrates that they would be better off receiving 100% of their lien from fewer law suits. Nor have they proffered any evidence to refute the Seventh Circuit's point in Blackburn v. Sundstrand Corp., 115 F.3d 493, 496 (7th Cir. 1997), that such a provision would likely give the injured person "every reason to disclaim any demand for medical expenses in tort suits, throwing on plans the burden and expense of collection." This burden will not necessarily inure to the interests of all

⁷ Although some amici claim that they may compromise their lien, they have no obligation to do so, and participants cannot rely on whether the trustees are feeling generous on a particular day. A result favorable to the plans here would certainly substantially reduce such generosity.

beneficiaries; in fact, the opposite is more likely to be true.

Moreover, in contrast to Petitioner's amici "sky is falling" arguments, there is evidence that the inability to obtain reimbursement recoveries has not threatened the viability of plans that are insured, rather than self-funded. In states that have prohibited or limited such reimbursement, these plans have survived, with comparable or lower premiums to those of self-funded ERISA plans. Kaiser Family Found. & Health Research & Educ. Trust, Employer Health Benefits: 2012 Annual (2012).14. 28 available Survey 20. http://ehbs.kff.org/pdf/2012/8345.pdf. Although states prohibit subrogation many reimbursement provisions in insurance contracts, each of those states continues to have insurance companies offering health insurance in their states. See Brief for Respondent, at 51-54, McCutchen, No. 11-1285 (June 5, 2012).

And, it appears that some health plans have concluded that they obtain more reimbursements by agreeing to pay their shares of reasonable attorneys' fees and expenses where participants sue third-party tortfeasors. Indeed, the plan in Sereboff expressly agreed to pay its share of the reasonable attorneys' fees and court costs. See Mid Atl. Med. Servs., LLC v. Sereboff, 407 F.3d 212, 215 (4th Cir. 2005).

CONCLUSION

For the foregoing reasons, amici AARP and NELA respectfully urge the Court to affirm the judgment of the court of appeals.

Respectfully submitted,

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Dated: October 25, 2012

AMICUS CURIAE BRIEF

OCT 2 5 2012

No. 11-1285

IN THE

Supreme Court of the United States

U.S. AIRWAYS, INC.,

Petitioner,

V.

MCCUTCHEN, ET AL.

Respondents.

On a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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IDENTITY AND INTEREST OF AMICUS CURIAE

The American Association for Justice ("AAJ") is a voluntary national bar association whose members primarily represent plaintiffs in personal injury actions. AAJ is committed to the principle that wrongdoers and those who create unreasonable risks should be held accountable for the harm they cause. Effective tort liability law not only provides compensation to those who face medical expenses and lost income due to wrongful injury, it prevents injury by promoting safety.

AAJ is concerned that allowing ERISA plans to demand reimbursement out of their beneficiary's tort award or settlement without contributing their share of legal costs will discourage wrongfully injured persons from pursuing their tort remedies, undermining the health and safety of all Americans as well as reducing reimbursement of ERISA plans.¹

SUMMARY OF ARGUMENT

1. The focus of this case is on the limitation "appropriate equitable relief" authorized by Congress in § 502(a)(3) of the Employee Retirement Income Security Act of 1974 ("ERISA"). Petitioner asserts that ERISA plans should be entitled to define for themselves the equitable remedies available to them and that strict

¹ Letters from counsel for all parties evidencing their consent to the timely filing of amicus curiae briefs have been filed with the Court. Pursuant to Rule 37.6, amicus discloses that no counsel for a party authored any part of this brief, nor did any person or entity other than amicus, its members, or counsel make a monetary contribution to its preparation.

enforcement of the plan as written is always "appropriate."

Amicus AAJ agrees with Respondents that the statutory text authorizes courts to limit the amount of an equitable lien by agreement based on the principles that courts of equity typically applied. AAJ is specifically concerned that an ERISA plan that received reimbursement out of a beneficiary's tort recovery should be obliged to pay its fair share of the legal fees which created that common fund.

The common fund doctrine is firmly rooted in the historic equity powers of the courts. Indeed, this Court recognized and repeatedly applied the doctrine in the days of the divided bench. The rule continues to be widely recognized by state and federal courts in the subrogation context to prevent those who share in the benefits of a lawsuit from becoming unjustly enriched by avoiding paying their share of the legal costs.

Application of the common fund doctrine does not require an explicit directive in § 502(a)(3). The doctrine is rooted in the courts' inherent equity powers. Congress has given no indication that it intended to remove that authority in ERISA actions. Indeed, ERISA was enacted in response to scandals in which workers lost their pension benefits due to negligence and misfeasance by employers and fund administrators who were allowed to operate without standards or oversight. It is unlikely that Congress intended to remove the traditional equity powers of the courts and instead invite employers and plan administrators to write their own rules governing lawsuits against their own beneficiaries under § 502(a)(3).

Finally, the calculation of the plan's fair share of attorney fees should be easy and transparent: The plan should pay the same percentage of its reimbursement as the beneficiary agreed to pay his or her contingency fee attorney out of the recovery. There is no need or logical reason for a laborious inquiry into the value of the attorney's services to the plan. The retainer agreement between the beneficiary and the attorney provides a reliable marketplace assessment of the value of the attorney's services, including the value of bearing the risk of non-recovery.

That simple means of calculating the share of the fee owed by the plan does not affect the wellsettled rule that the court may alter or set aside a contingency fee agreement that is excessive or grossly unfair to the client.

Requiring ERISA plans to pay their proportional share of the attorney fees incurred to make reimbursement possible will actually reduce the costs of ERISA plans for employers and employees. Most federal courts outside the Third Circuit allow ERISA plans a free ride by receiving the benefits of the services of their beneficiaries' personal injury attorneys' services without paying for them. However, the amount of free services ERISA plans actually receive, the insurance industry's own figures show, is a miniscule percentage of premiums. Faced with the prospect of becoming economically worse off as a result of winning a tort award, many injured ERISA beneficiaries simply do not pursue their state tort law rights.

Providing for payment of the legal costs required to obtain reimbursement funds will remove

this disincentive for beneficiaries to hold tortfeasors accountable. Data confirms that the common fund doctrine lowers the cost of employee health insurance plans. Average premiums for fully insured plans, which are subject to state law common fund and make-whole doctrines, are significantly less than the average self-funded ERISA plan, such as Petitioner's. Thus, requiring ERISA plans to pay for the attorney services that make reimbursement possible may lower plan costs in the long run.

3. The common fund doctrine also furthers important state interests. Requiring beneficiaries to pay the legal costs for reimbursing their medical plan is a strong financial disincentive to pursuing tort actions against those responsible for wrongful injury. Tort law is one of the means by which a state exercises its police power to safeguard the health and safety of their citizens. States not only have an interest in providing compensation to those who face medical expenses and lost income due to wrongful injury, they also have an interest in deterring such injuries in the first place by holding tortfeasors accountable. There is no indication that Congress intended to override this important state role.

ARGUMENT

I. INTRODUCTION

The focus of this case is a single phrase – actually a single word – in the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq. In Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356 (2006), this Court examined section 502(a)(3), which provides:

A civil action may be brought... by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief

- (i) to redress such violations or
- (ii) to enforce any provisions of this subchapter or the terms of the plan[.]

29 USC § 1132(a)(3) (emphasis added), 547 U.S. at 361...

This Court held in Sereboff that "equitable relief' includes an equitable lien "by agreement" to reimburse an ERISA plan. pursuant reimbursement provision in the plan document, out of the proceeds of a beneficiary's tort award. Id. at 365. The Court did not decide whether "appropriate" equitable relief calls upon courts to exercise their traditional equitable powers to limit the amount of reimbursement when the tort proceeds insufficient to fully compensate both parties. See id. at 368 n.2. That question is squarely presented here.

The primary argument urged by U.S. Airways, with the support of amici representing plan sponsors and administrators, is that an ERISA plan is entitled to strict enforcement of its provisions as written. Brief for Petitioner ("Pet. Br.") 17-18.2 See also Brief

² Petitioner incongruously insists that Plan provisions be strictly enforced while, as the Solicitor General points out, it has not bothered to introduce the plan documents themselves or make them part of the record. Brief for the United States ("U.S. Br.") 3 n.2. The parties appear to have treated the Summary Plan Description, including its reimbursement provision, as an

for National Association of Subrogation Professionals, et al. ("NASP Br.") 7-19; Brief of Chamber of Commerce, et al. 6 & 9; Brief of Central States Fund, et al. 14.

In their view, although Congress precluded plans from suing participants and beneficiaries for breach of contract, plans should obtain the same result by virtue of an equitable lien under § 502(a)(3), unencumbered by the limitations and defenses that traditionally accompanied equitable relief. In this way, plans could nullify the courts' equitable powers and contract away even the most elemental obligations of fair treatment.

Amicus AAJ agrees with Respondents that where the specified fund identified for reimbursement is insufficient to fully compensate both the plan and the beneficiary, the court may limit the amount of the plan's equitable lien on the fund. Brief for Respondents ("Resp. Br.") 15-25.

If U.S. Airways is entitled to some reimbursement out of the fund that Respondents have created by pursuing their cause of action against the tortfeasor, the Court is presented with another question concerning the appropriate amount

accurate reflection of the actual terms of the written plan document. The SPD itself warns, however, that it "is only a summary" and that "[i]f there is any difference between the information in this SPD and the legal plan document, the legal plan document will govern." U.S. Airways Complaint, Exhibit A at 20.

This Court has made clear that provisions of the SPD are not themselves enforceable. CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1878 (2011). AAJ urges the Court to make clear in this case that it has not weakened this important principle.

of equitable relief: Can a court require Petitioner to bear its share of the attorney fees and legal costs incurred by Respondents?³

The answer is clearly yes.

- II. COURTS MAY REQUIRE ERISA PLANS SEEKING REIMBURSEMENT FROM A COMMON FUND CREATED BY TO BENEFICIARY BEAR SHARE PROPORTIONATE OF LEGAL EXPENSE AND ATTORNEY FEES BY INCURRED BENEFICIARY IN CREATING THE FUND.
 - A. The Common Fund Doctrine Is Rooted in the Historic Equity Powers of the Courts.

This Court has consistently interpreted the term "appropriate equitable relief" in § 502(a)(3) as referring to "those categories of relief that, traditionally speaking (i.e., prior to the merger of law and equity) were typically available in equity." CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1878 (2011) (internal quotations omitted, emphasis in original). See also Sereboff, 547 U.S. at 361-62 ("The scope of remedial power conferred on district courts by § 502(a)(3)" is defined by the types of relief rendered by courts of equity during 'the days of the divided bench.") (quoting Great-West Life & Annuity Ins. Co.

³ The plan in Sereboff expressly agreed to pay its share of the reasonable attorney fees and court costs incurred by beneficiaries in securing the third-party payments. Mid Atlantic Med. Servs., LLC v. Sereboff, 407 F.3d 212, 215 (4th Cir. 2005). This Court was therefore not asked to address the issue. See 547 U.S. at 360.

v. Knudson, 534 U.S. 204, 212 (2002). The common fund doctrine is one such limitation on equitable relief that was typically and historically employed by courts sitting in equity, including this Court.

The common-fund doctrine refers to the "equitable principle underlying a federal court's power to award counsel fees out of a fund created or preserved through someone's efforts." 10 Charles Alan Wright, Arthur R. Miller & Mary Kay Kane, Federal Practice and Procedure § 2675 (3d ed. 1998). The treatises this Court looked to for a description of equity practice during the days of a divided bench, see Knudson at 217, similarly describe the common fund doctrine traditionally applied by equity courts. See, e.g., 2 George E. Palmer, Law of Restitution § 10.8, 431 (1978); 1 Dan B. Dobbs, Law of Remedies § 3.10(2) (2d ed. 1993).

This Court's own description of this equitable doctrine is that "a litigant or a lawyer who recovers a common fund for the benefit of persons other than himself or his client is entitled to a reasonable attorney's fee from the fund." Boeing Co. v. Van Gemert, 444 U.S. 472, 478 (1980). The purpose of the common fund doctrine is to prevent "persons who obtain the benefit of a lawsuit without contributing to its cost [from being] unjustly enriched at the successful litigant's expense." Id.

An early application of the common fund doctrine as a limitation on equitable claims for reimbursement out of tort recovery was articulated by the Supreme Court of Ohio:

[Where an insured has sustained a loss,] he has an undoubted right to have

it satisfied by actions against the wrong-doer. But if, by such action, there comes into his hands, any sum for which, in equity and good conscience, he ought to account to the underwriter, reimbursement will, to that extent, be compelled in an action by the latter, based on his right in equity to subrogation. But, the assured will not, in the forum of conscience, be required to account for more than the surplus, which may remain in his hands, after satisfying his own excess of loss in full, and his reasonable expenses incurred in its recovery.

Newcomb v. Cincinnati Ins. Co., 22 Ohio St. 382, 388 (1872) (emphasis added).

This Court first invoked the common fund doctrine in Trustees v. Greenough, 105 U.S. 527 (1881), in a suit involving bonds of the Florida Railroad Company secured by property held in trust. One bondholder, Vose, sued to set aside a fraudulent real estate sale that had undermined the bonds' value. After he succeeded in restoring the value of the bonds, he sought contribution from the other bondholders for the legal expenses he incurred. See id. at 529. The Court held that Vose was entitled to reimbursement by the nonparty bondholders. To deny Vose's claim "would not only be unjust to him, but it would give to the other parties entitled to participate in the benefits of the fund an unfair advantage." Id. at 532.

Shortly thereafter, in Central Railroad & Banking Co. v. Pettus, 113 U.S. 116 (1885), the Court

applied the doctrine and recognized an independent cause of action by the attorney for his fees which may be enforced by an equitable lien on the fund. This Court emphasized the equity rule, explaining that those who accepted "the fruits of the labors" of the attorneys should expect to be called upon to contribute to the expenses, including reasonable attorney fees. *Id.* at 127.

In Sprague v. Ticonic National Bank, 307 U.S. (1939), it was the client who sued for contribution for litigation expenses and counsel fees, to be paid out of a clearly identified fund, bonds that had been set aside and earmarked as the subject of express trust previously created. Frankfurter wrote for the Court that the "power of federal courts in equity suits to allow counsel fees and other expenses" incurred by a client to achieve a result which benefits others "is part of the historic equity jurisdiction of the federal courts . . . ever since the First Judiciary Act, 1 Stat. 73, constituted that body of remedies, procedures and practices which theretofore had been evolved in the English Court of Chancery," id. at 164, and was "part of the original authority of the chancellor to do equity in a particular situation." Id. at 166.

Thereafter, this Court consistently maintained that it is "a general rule in courts of equity that a trust fund which has been recovered or preserved through [a litigant's] intervention may be charged with the costs and expenses, including reasonable attorney's fees, incurred in that behalf." United States v. Equitable Trust Co., 283 U.S. 738, 744 (1931). See also Fleischmann Distilling Corp. v. Maier Brewing Co., 386 U.S. 714, 719 (1967) (The common-fund rule is based on the equity rationale

that "to have allowed the others to obtain full benefit from the plaintiff's efforts without requiring contribution or charging the common fund for attorney's fees would have been to enrich the others unjustly at the expense of the plaintiff."); Hall v. Cole, 412 U.S. 1, 7 & n.7 (1973) (Common-fund doctrine supported award of attorney fees in suit under Labor-Management Reporting and Disclosure Act); Bloomer v. Liberty Mut. Ins. Co., 445 U.S. 74, 88, n.15 (1980) (Noting "the established power of a court of equity to charge beneficiaries with a proportionate share of the costs of creating a common fund through litigation.").

In Alyeska Pipeline Services Co. v. Wilderness Society, 421 U.S. 240 (1975), this Court engaged in a comprehensive review of court-awarded attorney fees in federal courts. Justice White wrote for the Court that the common fund doctrine articulated and applied in Greenough, Pettus and Sprague, is grounded in:

[T]he historic power of equity to permit
... a party preserving or recovering a
fund for the benefit of others in addition
to himself, to recover his costs,
including his attorneys' fees, from the
fund or property itself or directly from
the other parties enjoying the benefit.
That rule has been consistently
followed.

Id. at 257-58 (citing decisions).

"The Greenough version of the common fund doctrine has found universal approval by state courts because it is so firmly rooted in the equitable power to grant restitution in order to prevent unjust enrichment or deter fiduciary misconduct." Lloyd C. Anderson, Equitable Power to Award Attorney's Fees: the Seductive Appeal of "Benefit," 48 S.D. L. Rev. 217, 226 (2002-03). State courts have invoked this equitable doctrine to prevent the problem of free riding insurers who seeking to benefit from the efforts of their insureds to recover damages from tortfeasors. See generally Johnny Parker, The Common Fund Doctrine: Coming of Age in the Law of Insurance Subrogation, 31 Ind. L. Rev. 313, 337 (1998) ("All states, except New Hampshire and Wyoming, have adopted the common fund doctrine" in the subrogation context.).

B. Courts Retain Their Equity Powers in Actions Seeking Equitable Relief Under ERISA Under § 502(a)(3).

Petitioner and its amici argue that in the absence of authorization in § 502(a)(3), the written terms of plans trump traditional equity doctrines such as the common fund rule. See Pet. Br. 37; NASP Br. 7-12.

However, the equitable powers of the courts are inherent powers and do not depend upon congressional authorization. This Court made clear in *Greenaugh* that the courts retain their equitable powers regarding fees, even when Congress has itself addressed the subject of fees in the relevant statute.

As this Court subsequently explained in Alyeska, Congress had undertaken in 1853 "to standardize the costs allowable in federal litigation" and eliminate the "exorbitant fees for the victor's attorneys" being imposed on losing litigants. Alyeska,

at 251: Nevertheless, the *Greenough* Court held that the statute did not "take away the power of a court of equity to permit counsel fees" under the commonfund doctrine. 105 U.S. at 535. An equity court retains that authority unless the language of the statute

[C]an be fairly construed to deprive the Court of Chancery of its long-established control over the costs and charges of the litigation, to be exercised as equity and justice may require, including proper allowances to those who have instituted proceedings for the benefit of a general fund.

Id. at 536.

This Court has ruled similarly with regard to other statutes. See, e.g., Hall v. Cole, 412 U.S. 1, 10 (1973) (Authorization of "appropriate" relief in Labor-Management Reporting and Disclosure Act, 29 U.S.C. § 412, leaves in place the equitable power of the court to award attorney fees); Mills v. Electric Auto-Lite Co., 396 U.S. 375, 391-92 (1970) (Securities Exchange Act of 1934 does not circumscribe the court's equitable power to award attorney fees under the common-fund doctrine).

In this case, nothing in ERISA's statutory text can be fairly construed as depriving the courts of their equitable powers. To the contrary, this Court has pointed out that § 502(a)(3) authorizes not only equitable relief, but also, rather more broadly, "invokes the equitable powers of the District Court." Amara, 131 S. Ct. at 1880 (emphasis added).

The very use of the modifier "appropriate" indicates Congress' intent that the courts exercise their equitable authority. See School Comm. of Burlington v. Dep't. of Educ. of Mass., 471 U.S. 359, 374 (1985) ("[T]he court was correct in concluding that 'such relief as the court determines is appropriate,' within the meaning of [the Education of the Handicapped Act, § 615(e), as amended, 20 U.S.C.A.] § 1415(e)(2) (2010), means that equitable considerations are relevant in fashioning relief.").

As this Court noted with reference to injunctive relief authorized by § 502(a)(3)(A), "statutory reference to that remedy must, absent other indication, be deemed to contain the limitations upon its availability that equity typically imposes. Knudson, at 211 n.1 (emphasis added). Clearly the equitable remedy sought by U.S. Airways in this case must be deemed to be subject to the limitations equity typically imposes, including the common fund doctrine.

That result comports with the background against which Congress acted. This Court has repeatedly observed that ERISA is "the product of a decade of congressional study of the Nation's private employee benefit system." Knudson, 534 U.S. at 209 (quoting Mertens v. Hewitt Assocs., 508 U.S. 248, 251 (1993)). Congress acted against a backdrop of scandal and distrust. As one of the chief authors of the statute has noted, much of the impetus for ERISA's enactment was the financial failure of the Studebaker-Packard automobile company, many workers who had paid into the employee pension program for years were left with little or nothing. Michael S. Gordon, Overview: Why Was ERISA Enacted?, in Senate Special Comm. on Aging, 98th

Cong., 2d Sess., The Employee Retirement Income Security Act of 1974: the First Decade 8 (Comm. Print 1984). The pension failure was blamed on underfunding, mismanagement, and wrongdoing on the part of the company, fund administrators, and the UAW. James A. Wooten, "The Most Glorious Story of Failure in the Business": The Studebaker-Packard Corporation and the Origins of ERISA, 49 Buff. L. Rev. 683, 697-716 (2001).

Moreover, at the time Congress was fashioning ERISA, the great majority of states applied the common-fund doctrine in the context of insurance subrogation. Parker, at 333-34; see also J.F. Riley, Annot., Right of Attorney for Holder of Property Insurance to Fee Out of Insurer's Share of Recovery From Tortfeasor, 2 A.L.R.3d 1441 at § 2 & 3 (1965).

This history strongly indicates that Congress intended that the courts would play an active role in "construing the private remedy that Congress explicitly provided in § 502(a)(3)." Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 155 (1985) (Brennan, J., concurring). It does not indicate that Congress intended to deprive the courts of their equitable powers. Nor does it suggest that Congress employers intended to invite and administrators to write their own favorite rules governing their claims for equitable relief simply by inserting them into plan documents.

- C. The Plan's Equitable Share of Attorney Fees Is Calculated by Multiplying the Amount the Plan Receives by the Percentage Contingency Fee the Beneficiary Paid the Attorney to Pursue the Claim.
- U.S. Airways raises an additional concern. speculating that the method of calculating the Plan's fair share of attorney fees would result in "costly" and "endless" litigation. Pet. Br. 49. Petitioner reaches this alarming conclusion by asserting that it should not be obliged to pay the proportional share of its reimbursement that matches the percentage paid by the beneficiary. Instead, "a federal judge in every case would need to determine an appropriate fee for the plan member's counsel by quantifying the nearly unquantifiable: 'the value of the services' the plan member's attorney rendered to the plan." Id. at 48. Reporter's referring to the Illustration accompanying Restatement (Third) of Restitution & Unjust Enrichment § 29 (2011).4

⁴ Illustration 26 is based on Brown v. T.W. Phillips Gas & Oil Co., 105 F. Supp. 479 (W.D. Pa. 1952), where three fire insurance companies sought reimbursement out of the property owner's tort judgment against the wrongdoer. The district court ordered that each insurer pay its share of the attorney fees and costs. Rather than apply the attorney's contingency fee percentage to each insurer's reimbursement, the court indicated it would hold a hearing to arrive at a fair fee. Id. at 482. This case does not appear to reflect usual practice in tort personal injury subrogation. The court cited no authority for conducting a fee hearing in a subrogation matter, but instead looked to the "principles of equity applied in class actions and decedents' estates." Id. at 481. Nor has this decision been cited for that point, apart from its use as a basis for an illustration in the modern restatement.

Petitioner argues that it is entitled to a large portion of Mr. McCutchen's tort settlement without Petitioner contributing to its cost because the calculations required to determine its fair share "are not, after all, simple or mathematical; they are intensely factual and circumstance-specific, and they would embroil federal courts and litigants in resource-consuming litigation." Pet. Br. 49.

To the contrary, the fee calculation is mathematical and fairly simple. If the attorney has undertaken to pursue plaintiff's cause of action for 33 percent of the recovery, if any, and the plan receives all or part of the recovery, the plan's fee is 33 percent of its recovery — it pays the same percentage of its recovery as the tort plaintiff paid on his.

It is true that in other common fund contexts, such as class actions, the court will inquire into the number of hours spent by counsel, the difficulty of the case and other factors. Plaintiffs in personal injury actions are almost invariably represented on a contingency fee basis, which provides a ready and accurate means of calculating the amount of unjust enrichment if the plan is not required to contribute to the legal costs of making its reimbursement possible.

The contingent fee represents "the dominant system in the United States by which legal services

6

Significantly, the only other decision the Restatement Reporter cites regarding the calculation of fees was Guiel v. Allstate Insurance Co., 756 A.2d 777 (Vt. 2000), in which the court upheld a common-fund fee award that applied the plaintiff's agreed-upon contingency-fee percentage. Id. at 785.

are financed by those seeking to assert a claim." F. MacKinnon, Contingent Fees for Legal Services 4 (1964). It serves as the "key to the courthouse" for the vast majority of ordinary Americans, who could not otherwise afford to pursue their rights at the profession's prevailing hourly rates, See Philip H. Corboy, Contingency Fees: The Individual's Key to the Courthouse Door, 2 Litigation 27 (Summer 1976); Peter Karsten, Enabling The Poor To Have Their Day In Court: The Sanctioning Of Contingency Fee Contracts, A History To 1940, 47 DePaul L. Rev. 231 (1998). The contingency fee lawyer provides access to affordable legal representation by agreeing to be paid as a percentage of the recovery, thus bearing the risk of losing the case.

For that reason, the time-consuming fee inquiry Petitioner envisions is illogical as well as unnecessary. The value of the contingency fee lawyer's services is not measured after the contingency has come to pass and the attorney has succeeded and reimbursement of the plan is ensured. The plan could have invoked its subrogation rights and brought suit with its own attorney.

The value of allowing McCutchen's attorney to pursue the claim includes the value of the attorney bearing the risk of loss. That value in this case was set by the attorney and client at the time the litigation commenced. See Pennsylvania v. Delaware Valley Citizens' Council for Clean Air, 483 U.S. 711, 731 (1987) ("The private market commonly compensates for contingency through arrangements in which the attorney receives a percentage of the damages awarded to the plaintiff.") (O'Connor, J., concurring). McCutchen and his attorney agreed at that time as to the value of the attorney's services.

Thus, Professor Dawson states that, in contrast to class actions and other common-fund contexts, the prevailing rule in subrogation cases is that "the contingent fee arrangements between the lawyer and his client were carried over and applied to the 'fund." John P. Dawson, Lawyers and Involuntary Clients: Attorney Fees from Funds, 87 Harv. L. Rev. 1597, 1623 n.85 (1974) (citing cases).

The Solicitor General makes a somewhat different observation, that the beneficiary who has provided a fund from which the plan can obtain reimbursement "is not necessarily entitled to a mechanical, pro rata apportionment," of the agreed-upon contingency fee and that the court should review the fee for reasonableness. U.S. Br. 27 n.10 (citing *Pettus*, 113 U.S. at 128).

In fact, this Court in *Pettus* did not instruct federal courts to look for a "reasonable" percentage fee different from the percentage the attorney had agreed upon with the client. To the contrary, the Court found it an abuse to charge a different percentage to the fund from what the client had agreed to pay. Plaintiffs in that case had retained their attorney for five percent of the bonds and coupons involved, but were awarded ten percent out of the common fund. *Id.* at 128. The Court, reversing, could "perceive no reason for this discrimination against creditors who were not parties" and remanded to recalculate their fees using the same percentage agreed upon by the client. *Id.*

Amicus emphasizes that it is not unfair that the subrogee be bound by the agreement between the attorney and client. "[T]he insurer that wishes to avoid application of the common fund doctrine in cases may do so by the simple act of refusing to accept the benefits of a settlement in which it did not participate." Lopez v. Farm Bureau Mut. Ins. Co., 148 Idaho 515, 519, 224 P.3d 1104, 1108 (2010).

Amicus also notes that declining to require an individualized inquiry in every case to evaluate the reasonableness of applying the contingency fee percentage to the plan's recovery does not diminish the courts' well-settled authority to alter or set aside a contingent fee that is unconscionable to the client. See, e.g., Schlesinger v. Teitelbaum, 475 F.2d 137, 141 (3d Cir. 1973). See also, Kalyawongsa v. Moffett, 105 F.3d 283, 286 (6th Cir. 1997) ("federal district judges have broad equity power to supervise the collection of attorneys' fees under contingent fee contracts") (quoting Krause v. Rhodes, 640 F.2d 214, 218 (6th Cir. 1981)). See generally, Robert L. Rossi, Attorney's Fees § 2.8-2.10 (2d ed. 1995).

- III. APPLICATION OF THE EQUITABLE COMMON FUND DOCTRINE UNDER 502(A)(3) WILL REDUCE PLAN COSTS AND PREMIUMS BY ENCOURAGING TORT ACTIONS THAT WILL FUND REIMBURSEMENT.
 - A. Any Increased Premium Cost Due to Requiring ERISA Plans to Contribute Their Proportional Share of the Attorney Fees Would Be Miniscule.
- U.S. Airways and its supporting amici argue that limiting reimbursements will devastate ERISA plans economically, leading many employers to raise premiums substantially and others to discontinue

medical coverage altogether. They reason that full reimbursement out of third-party tort judgments and settlements is essential to keeping down the costs of ERISA medical plans. See Pet. Br. 42-46; NASP Br. 24-26.

It must be acknowledged at the outset, however, that Congress' primary goal in enacting ERISA was not to reduce the cost of employee benefit plans. It was to safeguard their integrity. The "legislative history of ERISA reveals that Congress was, in large part, motivated by 'the absolute need that safeguards for plan participants be sufficiently adequate and effective to prevent the numerous inequities to workers under plans which have resulted in tragic hardship to so many." David M. Kono, Unraveling the Lining of ERISA Health Insurer Pockets - A Vote for National Federal Common Law Adoption of the Make Whole Doctrine, 2000 B.Y.U. L. Rev. 427, 444 (2000) (quoting H. R. Rep. No. 93-533, at 9 (1974), reprinted in 1974 U.S.C.C.A.N. 4639, 4647). Cf. Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 515 (1981) (noting that Congress in enacting ERISA had "the primary goal of benefiting employees and the subsidiary goal of containing pension costs.").

Obviously a plan might reduce its costs by shifting administrative expenses to its injured claimants. But the principle of health insurance is to the spread risk of large expense by assessing a relatively small premium among many insureds when they are relatively healthy. Petitioner favors imposing all of a large administrative expense on a small number of injured beneficiaries for the purpose of saving the many healthy participants a very slight

amount in premiums. It is insurance running in reverse.

How exceedingly slight the maximum savings would be is demonstrated by the figures cited by Petitioner itself. U.S. Airways states that ERISA "plans recover more than \$1 billion annually under reimbursement provisions," the loss of which could result in "potential loss of insurance coverage." Pet. Br. 42-43 (citing Health Economics Practice, Barents Group, LLC, Impacts of Four Legislative Provisions on Managed Care Consumers: 1999-2003 (1998)). See also BCBS Br. 12 (estimating that "plans recover over \$1 billion each year through subrogation and reimbursement."). The Barents Group estimates that employers and employees pay approximately \$300 billion in premiums to those Thus. reimbursements Barents. at 1. represent about one-third of 1 percent of premiums.

A substantial portion of those reimbursements have nothing to do with third party tort recoveries. Many, if not most, are recoveries of overpayments or erroneous payments. About a third of that smaller number, less than ten cents of every \$100 in premiums, roughly represents the ERISA plans' proportional share of attorney fees.

Nor are employers with self-funded plans, as in this case, obliged to use reimbursements to reduce premiums. Amicus Blue Cross/Blue Shield lectures, "Every dollar blocked from subrogation or reimbursement recovery by an equitable defense is one less dollar for all plan participants to use for their current and future claims." BCBS Br. 12. Because reimbursements flow into the employer's general revenues, it can also be said that there is one

less dollar for executive bonuses, stockholder dividends, advertising campaigns or other purposes.

B. Preserving Financial Incentives for Beneficiaries to Bring Claims Against Tortfeasors Will Lower the Costs of ERISA Coverage for Employers and Employees.

The very small increase in administrative costs that might result from requiring ERISA plans to contribute their fair share of attorney fees incurred to provide a source of reimbursement would be far outweighed by the consequent increase in reimbursements.

Even if successful tort plaintiffs typically recovered their full losses, equity would require ERISA plans to pay their share of the attorney fees incurred to make reimbursement possible. But "scholarly research documents that more seriously injured victims tend to recover only a part of their total financial losses, notwithstanding the supposed legal entitlement to full compensation." Kenneth S. Abraham, Robert L. Rabin & Paul C. Weiler, Enterprise Responsibility for Personal Injury: Further Reflections, 30 San Diego L. Rev. 333, 340 (1993). In fact, the consistent "undercompensation [of personal injury plaintiffs] at the higher end is so well replicated that it qualifies as one of the major empirical phenomena of tort litigation." Michael J. Saks, Do We Really Know Anything About the Behavior of the Tort Litigation System - And Why Not? 140 U. Pa. L. Rev. 1147, 1218 (1992). Additionally, tort settlements are often necessary compromises in the face of inadequate insurance.

It has also been observed that "attorneys rarely work for free." Guiel v. Allstate Ins. Co., 756 A.2d 777, 780 (Vt. 2000). Commitments to staff salaries, rent, and other costs and expenses must be met. As Chief Judge Richard Posner has pointedly observed, rejecting the common-fund doctrine allows the plan "to free ride on the efforts of the plan participant's attorney." Wal-Mart Stores, Associates' Health & Welfare Plan v. Wells, 213 F.3d 398, 402 (7th Cir. 2000). Consequently, a victim of wrongful injury may face the prospect of owing the attorney a percentage of his own recovery, but also a percentage of the fund that was paid over to the ERISA plan. Many wrongful injury victims face the real possibility of "winning" their tort lawsuit, but finding themselves worse off than if they had not sued at all Id

This prospect, "gratuitously deter[s] the exercise of the tort rights" of many participants whose medical expenses were paid by ERISA plans. Id. They simply do not bring suit against tortfeasors responsible for their injuries.

The cost of rejecting the common fund doctrine is substantial. Amicus Blue Cross/Blue Shield indicates that fully insured plans are subject to state insurance laws that include the make whole doctrine and the common fund doctrine, while those doctrines have generally been held inapplicable to self-funded ERISA plans. BCBS Br. 16 n.12. See FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990) (plans that are fully insured by insurance companies are subject to state laws regulating insurance; those regulations are preempted as to ERISA plans that are fully funded by employer/employee contributions).

According to the Kaiser Foundation survey cited by Blue Cross, the average premium charged by the self-insured plans is 3.3 percent higher for individual workers and 7.3 percent higher for family coverage than for fully insured plans that are subject to the make whole and common fund doctrines. Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits: 2011 Annual Survey 26 & 27 (2011), at http://ehbs.kff.org.5

Thus, as Judge Easterbrook has pointed out, the common-fund doctrine "may even increase the plan's recoveries in the long run." Blackburn v. Sundstrand Corp., 115 F.3d 493, 496 (7th Cir. 1997).

IV. PUBLIC POLICY SUPPORTS THE BENEFICIARY'S EQUITABLE REMEDY FOR A PRO RATA SHARE OF ATTORNEY FEES.

As demonstrated in Part II above, rejecting the common-fund doctrine sets up a strong financial disincentive for ERISA participants to pursue their rights to seek compensation from tortfeasors. The consequences extend far beyond increasing the cost of ERISA plans. Such a rule undermines the interest of the states in holding tortfeasors accountable.

Tort liability is chiefly a matter of state law. "Throughout our history," this Court has stated, "the

⁵ The average annual premium for workers covered by fully insured plans in 2011 was \$5,324 for individuals and \$14,434 for families. For those covered by self-funded plans, the average premiums were \$5,499 and \$15,492 respectively. Kaiser, at 26-27, exhibits 1.5 & 1.6. Blue Cross/Blue Shield mistakenly reverses those survey results. See BCBS Br. 16 n.12.

several States have exercised their police powers to protect the health and safety of their citizens." Medtronic, Inc. v. Lohr, 518 U.S. 470, 475 (1996). These are "primarily, and historically, ... matter[s] of local concern." Id. (quoting Hillsborough Cnty. v. Automated Med. Labs. Inc., 471 U.S. 707, 719 (1985)). Hence, federal law must take into account the "legitimate and substantial interest of the State in protecting its citizens" through tort liability. Farmer v. United Bhd. of Carpenters & Joiners of America, 430 U.S. 290, 304 (1977).

States do so first by requiring that those who engage in harmful or unreasonably dangerous conduct bear the cost of the harms they cause. Liability is a powerful incentive to invest in safety. See Guido Calabresi, The Costs of Accidents 68-129 (1970) (tort liability acts as specific and general deterrent to accidents). See also American Bar Association. Towards a Jurisprudence of Injury 4-3 (1984) (deterrence of misconduct is "a strong thread running through tort law"); Gary T. Schwartz, Deterrence and Punishment in the Common Law of Punitive Damages, 56 S. Cal. L. Rev. 133, 137 (1982) ("There is now a rich body of academic literature supporting the view that a primary purpose of tort liability rules is to discourage inappropriate behavior.").

By discouraging ERISA beneficiaries from pursuing meritorious tort lawsuits, the rule Petitioner advocates weakens this safety incentive, which may be expected to result in an increase in accidental injuries. Some of the resulting medical expenses, of course, will be paid by ERISA plans.

"It is beyond dispute," this Court has also stated, that the States have "a significant interest in redressing injuries that actually occur within the State." Int'l Paper Co. v. Ouellette, 479 U.S. 481, 502 (1987) (quoting Keeton v. Hustler Magazine, Inc., 465 U.S. 770, 776 (1984)). Although federal law is supreme, the "State's interest in applying its own tort laws cannot be superseded by a federal act unless that was the clear and manifest purpose of Congress." Id. at 503.

If ERISA plans are not required to contribute a pro rata share of the attorney fees incurred by beneficiaries to create a fund from which plans might seek reimbursement, beneficiaries will not retain attorneys to do so. Plans will not be reimbursed for paid benefits, and beneficiaries will not obtain compensation for their other losses. The advantage under such a rule goes to the tortfeasor who is not made accountable for wrongful injury.

There is no indication in ERISA that Congress intended to undermine the role and responsibility of the States in this way.

CONCLUSION

For the foregoing reasons, the decision by the Court of Appeals for the Third Circuit should be affirmed.

October 25, 2012 Respectfully submitted,

JEFFREY R. WHITE

Counsel of Record

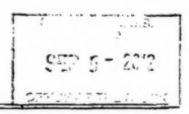
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AMICUS CURIAE BRIEF

No. 11-1285



In The

Supreme Court of the United States

U.S. AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN,

Petitioner,

V.

JAMES MCCUTCHEN and ROSEN LOUIK & PERRY, P.C.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals For The Third Circuit

BRIEF OF AMICI CURIAE THE BLUE CROSS BLUE SHIELD ASSOCIATION AND THE RAWLINGS COMPANY, LLC IN SUPPORT OF PETITIONER

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The Blue Cross Blue Shield Association (the "BCBSA") and The Rawlings Company, LLC ("Rawlings") respectfully submit this brief supporting the Petitioner as amici curiae.1

INTEREST OF AMICI CURIAE

BCBSA. BCBSA is the trade association that coordinates the national interests of the independent, locally operated Blue Cross and Blue Shield companies. Together, the 38 independent, community-based and locally operated Blue Cross and Blue Shield companies provide health insurance benefits to nearly 100 million people—nearly one-third of all Americans—in all 50 states, the District of Columbia, and Puerto Rico. The companies offer a variety of insurance products to all segments of the population, including large public and private employer groups, small businesses and individuals.

The Blue Cross and Blue Shield companies are subject to regulations under a variety of federal and state statutes, including the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§1001 et seq. This case concerns whether ERISA plan participants can use equitable defenses to override the plain terms of a reimbursement provision in an ERISA plan.

The Blue Cross and Blue Shield companies administer or insure ERISA plans that often include

¹No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of this brief. No one other than amici curiae, their members, or amici's counsel made a monetary contribution to the preparation or submission of this brief. Letters from the parties consenting to the filing of amicus briefs have been filed with the Clerk of the Court.

such reimbursement provisions. The funds they collect through reimbursement help reduce employers' contributions and employees' premiums for ERISA plans. If plan participants are allowed to use equitable principles to rewrite contractual language to excuse them from reimbursing their plan for benefits paid, ERISA plans will not be able to consistently enforce reimbursement provisions, and the plans and their participants will suffer significant negative financial consequences.

Rawlings is the largest and most established health insurance subrogation company in the country. With over 30 years of experience and over 600 employees serving both self-funded and insured employer sponsored plans, Rawlings is the largest subrogation recovery organization in the country in terms of the number of health plans served and the volume of health subrogation processed. As the first organization dedicated to providing subrogation services to health plans, Rawlings has pioneered major innovations in the field and has created industry best practices. In its role implementing the subrogation and reimbursement programs on behalf of health plans, Rawlings has recovered hundreds of millions of dollars in health care expenditures for insured and self-funded employee benefit plans through subrogation and recovery.

Rawlings has an interest in the issue presented in this case because it will directly impact Rawlings' ability to administer subrogation and recovery claims, which in turn will have far reaching implications by raising the cost of, and increasing the uncertainty in, the nation's health care system.

SUMMARY OF ARGUMENT

More than 160 million Americans get their health-care through employer-sponsored health insurance plans.² Of these covered workers, 60%—or approximately 96 million people—participate in a self-funded employer-sponsored plan.³ And this number is expected to increase significantly in the coming years. Beginning in 2014, companies with 50 or more employees will be required to either provide qualified health insurance coverage to their full-time employees and their dependents or pay a peremployee fee to the government. 26 U.S.C. §4980H. While smaller companies may be able to purchase

²Chad Terhune, About 10% of Employers To Drop Health Benefits, Study Finds, L.A. TIMES (July 24, 2012).

³Kaiser Family Foundation and Health Research and Edu. ² ional Trust, Employer Health Benefits: 2011 Annual Survey 150 (2011), available at http://ehbs.kff.org ("Employer Health Benefits").

There are two types of employer-sponsored health plans: fully-insured and self-funded plans. In a fully-insured plan, the employer buys a health plan from an insurer or managed care organization, which assumes financial responsibility for the costs of enrollees' medical claims. A self-funded plan is an arrangement in which the employer assumes direct financial responsibility for the costs of enrollees' medical claims. Self-funded plans utilize employee cost sharing arrangements similar to fully-insured plans, i.e. deductibles, co-payments and employee monthly contributions (which are functionally the same as premiums). ERISA applies to all employer-sponsored health plans, regardless of funding status. However, the funding status of the health plan is relevant to whether ERISA preempts various state laws. For self-funded plans, ERISA always preempts state laws. For fully-insured plans, by contrast, it often does not. See FMC Corp. v. Holliday, 498 U.S. 52, 61-62 (1990). Accordingly, the issue in this case—whether plan participants can revive otherwise preempted state law doctrines through the use of equitable defenses—more significantly impacts self-funded plans.

health care benefits via state insurance exchanges, health care benefits experts expect many larger employers will choose to self-fund rather than buy commercial coverage.⁴

The benefits of self-funded plans are many,⁶ but chief among them—at least until the decision below held otherwise—was that ERISA's preemption of state laws enabled them to maximize their resources to provide benefits by relying on the reimbursement rights and other cost savings provisions set forth in plan documents, without fear that a court would erase or alter those rights. Certainty with respect to their legal rights allows self-funded plans to minimize their litigation costs, maximize their recovery from third party tortfeasors and, ultimately, set lower employee contribution rates for all participants while offering the most comprehensive benefits the plan can afford.

The decision below holds that courts may apply equitable doctrines to alter plan terms—even when the plan includes unambiguous repayment provisions that plainly disclaim those doctrines. Although this may be appropriate where such provisions are lacking, it is inappropriate and ill-advised where, as here, the plan's reimbursement provision unambiguously requires the participant to fully reimburse the plan.⁶

⁴Joanne Wojcik, Reform Law Could Fuel Self Funding (Feb. 19, 2012), available at http://www.businessinsurance.com/article/20120219/NEWS05/302199999.

⁵See, e.g., Jonathan Edelheit & Daniel Pyne, The Benefits and Flexibility of Self-funded Insurance, SELF FUNDING MAGAZINE (Aug. 2, 2012), available at http://www.selffundingmagazine.com/article/the-benefits-and-flexibility-of-self-funded-insurance.html.

⁶As this Court has oft-repeated, the plain language of a (... continued)

If not reversed by this Court, the rule adopted by the decision below would eliminate the certainty these plans have relied upon and would have potentially devastating effects on self-funded employer-sponsored plans and their nearly one-hundred million participants. Specifically, in the subrogation and reimbursement context, it will increase plans' litigation costs and decrease the amount they can recover from third party tortfeasors, which will jeopardize plans' financial viability and result in reduced benefits and/or higher out-of-pocket payments for participants.

And the financial harm to plans will go far beyond the subrogation context and lost subrogation recoveries. If equity can be used to deny enforcement of plan terms regarding subrogation, then it might also be applied to many other terms that plans use to manage costs—from beneficiary eligibility requirements to medical provider reimbursement rates to exclusions of non-medically necessary treatments. If all of these terms are at risk of being erased or altered by courts, plans' funds will be even further depleted. Indeed, the mere risk that such terms could be undermined will force plans to divert funds from the benefits that they would otherwise intend to provide.

And all for no good reason. Under the current system, plans can—and usually do—work out a

⁽Continued . . .) statute is the touchstone of statutory interpretation. See Jimenez v. Quarterman, 555 U.S. 113, 118 (2009). The plain language of Section 502(a)(3) permits plan fiduciaries to pursue and obtain "appropriate equitable relief" to "enforce . . . the terms of the plan." 29 U.S.C. §1132(a)(3) (emphasis added). In other words, the critical statutory text contains an explicit directive regarding the specific text courts should follow—the plan's plain terms.

mutually beneficial resolution with the participant. extraordinarily rare-indeed, in amic's virtually unprecedented—that experience, participant is ever called upon to reimburse the plan's equitable lien from his own assets. In amici's experience, of subrogation reimbursement clauses universally limit the plan's rights only to funds that the plan member receives from a third party, never from funds that were originally in the member's pocket. If that unusual situation arose here, it arose only McCutchen agreed to a 40% contingency fee arrangement with his attorneys and then disposed of his personal injury settlement proceeds before he addressed his contractual obligation to reimburse US Airways.⁷ The plan—and the remaining plan members-should not suffer so that an individual participant and his attorneys can take benefits from the plan in disregard of the plan's terms.

The Third Circuit stated that McCutchen's net recovery was less than US Airways' \$66,000 lien. Pet. App. 3a. It presumably reached that conclusion by assuming that McCutchen's attorneys took a 40% contingency out of the full settlement amount. But the record does not reflect this. It reflects, instead, that his attorneys took a 40% contingency out of one portion of the settlement. JA 59; see also Brief for Petitioner at 10 n.3.

ARGUMENT

I.

ALLOWING COURTS TO VARY UNAMBIGUOUS PLAN TERMS WOULD INCREASE COSTS FOR PARTICIPANTS AND THREATEN PLANS' FINANCIAL VIABILITY

A. Allowing Courts To Disregard Plan Terms Would Increase The Cost Of Administering ERISA Plans

Before the Third Circuit's decision in McCutchen. governing plans' subrogation reimbursement rights were clear and uniform: plans that included unambiguous repayment provisions in their plan documents were entitled to obtain full reimbursement of all medical benefits paid by the plan. See Zurich Am. Ins. Co. v. O'Hara, 604 F.3d 1232, 1237 (11th Cir. 2010), cert denied, 131 S. Ct. 943 (2011); Admin. Comm. of Wal-Mart Stores Assocs.' Health & Welfare Plan v. Shank, 500 F.3d 834, 838 (8th Cir. 2007); Moore v. CapitalCare, Inc., 461 F.3d 1, 10 (D.C. Cir. 2006); Bombardier Areospace Employee Welfare Benefits Plan v. Ferrer. Poirot, & Wansbrough, 354 F.3d 348, 357 (5th Cir. 2003); Admin. Comm. of Wal-Mart Stores Assocs.' Health & Welfare Plan v. Varco, 338 F.3d 680, 692 (7th Cir. 2003). Plans did not have to delve into the specific facts of each unique case to assess whether they had a right to recovery; they could rely on the plain terms of the plan to work with the plan participant to obtain the reimbursement to which they were entitled, or otherwise to work out a mutually beneficial resolution with the participant.

Most often, this process is resolved through negotiation among the interested parties without the need for court intervention. And in the rare cases in which a lawsuit between the plan and the participant has arisen, the scope of the litigation was usually limited to a relatively straightforward question of contract interpretation: whether the plan terms obligated the beneficiary to reimburse the plan from any judgment or settlement received, regardless of possible equitable defenses like the "made whole" and "common fund" doctrines. See 16 LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INSURANCE §223:141-142 (3d ed. 2005) ("COUCH ON INSURANCE") (citing cases in which courts analyzed plan language to determine whether it was sufficient to disclaim the made whole rule). By contrast, if plan participants can induce courts to alter the unambiguous terms of an ERISA plan by invoking equitable defenses, even when the plan specifically disclaims these equitable defenses, that risk would introduce significant uncertainty-and significant new costs—into plan administration and litigation.

For instance, under the equitable principle known as the common fund doctrine, a plan may be held responsible to share the costs and fees incurred as a result of the plan participant's efforts to recover from the third party tortfeasor. But the doctrine only applies if the costs incurred by the plan participant are actually "of benefit" to the plan. 16 COUCH ON INSURANCE §223:116 (explaining that a plan may have a colorable claim that they received no benefit if the plan participant proceeds against the tortfeasor without informing the plan, and the plan could have proceeded proceed directly against the tortfeasor under a subrogation theory). Accordingly, the parties would have to engage in discovery and

litigation to determine whether "[the plan participant's] efforts benefited [the plan] or were reasonably necessary to [the plan's] recovery." Desmond v. Liberty Nw. Ins. Corp., 817 P.2d 872, 875 (Wash. Ct. App. 1991) (holding the record inadequate "to allow the trial court to determine whether [the plan participant's] efforts benefited [the plan] or were reasonably necessary to [the plan's] recovery" and remanding to the trial court "to take such further evidence as will permit it to properly make this determination").

Moreover, under the common fund doctrine, a plan is only liable for a share of reasonable attorney's fees. The reasonableness of fees is not determined solely by reference to the contingency fee agreement between the plan participant and his attorney. Rather, in determining the reasonable fees, courts must consider "the amount and nature of the services rendered and all factors relevant." Barreca v. Cobb. 668 So. 2d 1129, 1132 (La. 1996). Accordingly, the rule adopted below would require plans to seek substantial discovery and devote substantial time and resources to investigate and prove the number of hours spent by the participant's attorney, the complexity of the legal issues and the strength of the legal claims presented in the underlying case against the tortfeasor, and other relevant" to establishing reasonable "factors attorney's fees.

The same adverse effects would ensue by application of another equitable doctrine, the made whole doctrine, under which a plan would not be permitted to recover funds it was owed until the plan participant was fully compensated. That doctrine, too, requires a substantial case-specific analysis. Whether a plan participant has, in fact, been made whole can be a complicated and fact-intensive inquiry. Among the factors to be considered are:

1) the ability of parties to prove liability; 2) the comparative fault of all parties involved in the accident [8]; 3) the complexity of the legal and medical issues; 4) future medical expenses; 5) nature of injuries; and 6) the assets or lack of assets available above and beyond the insurance policy. (Provident Life & Acc. Ins. Co. v. Bennett, 483 S.E.2d 819, 825 (W. Va. 1997))

Investigating these factors will require additional fact discovery by plans. 16 COUCH ON INSURANCE §223:152 (noting that "[e]ach of these items is discoverable through the use of interrogatories and a notice to produce documents which should include all pleadings and discovery of the underlying action, including any discovery and investigation conducted therein and decisions of the court"). And litigating the question of whether the plan participant has been made whole would unjustifiably place an additional burden on plans and on the courts. See Jeffrey A. Greenblatt, Insurance and Subrogation: When the Pie Isn't Big Enough, Who Eats Last?, 64 U. CHI. L. REV. 1337, 1344 (1997) ("Who Eats Last?") ("Courts confronting this issue often conduct a minitrial to determine whether the insured has been made whole").

The equitable defense at issue below was unjust enrichment. Pet. App. 16a. In applying this principle to US Airways' claim for reimbursement, the

⁶Negligent plan participants are "made whole" when they receive payment for the percentage of their damages for which they were not at fault. See, e.g., Sorge v. Nat'l Car Rental Sys., Inc., 470 N.W.2d 5, 7 (Wis. Ct. App. 1991), aff'd, 512 N.W.2d 505 (Wis. 1994).

court expressed its view that, "[b]ecause the amount of the judgment exceeds the net amount of McCutchen's third party recovery, [and] leaves him with less than full payment for his emergency medical bills," it would be inequitable to require McCutchen to provide full reimbursement to US Airways. Id. In this respect, the equitable defense of unjust enrichment closely resembles the common fund or made whole doctrines. And the Third Circuit acknowledged that application of the equitable principle of unjust enrichment would require "full factual findings" in the trial court. Id. at 17a (quoting Nat'l City Mortg. Co. v. Stephen, 647 F.3d 78, 87 n.8 (3d Cir. 2011)); see also id. (remanding to the District Court with instructions to "engage in any additional fact-finding it finds necessary" and noting that "factors such as the distribution of the third-party recovery between McCutchen and his attorneys..., the nature of their agreement, the work performed, and the allocation of costs and risks between the parties to this suit" may all be relevant).

In sum, if courts were permitted to use equitable principles to rewrite contractual language and refuse to order participants to reimburse their plan, even where the plan's terms give it an absolute right to reimbursement, ERISA plans would be forced to investigate and demonstrate the propriety of reimbursement in each individual case. The net effect would be a substantial increase in the costs of pursuing subrogation/reimbursement claims.

B. Allowing Courts To Disregard Plan Terms Would Decrease The Amount Of Money In The Plan's Fund

With the introduction of equitable defenses to evade the enforcement of the plain plan language, plans inevitably would not be able to recover the full amounts that they are entitled to under their subrogation and reimbursement rights. The fiscal impact to plans would be substantial. It has been estimated that plans recover over \$1 billion each year through subrogation and reimbursement. Br. of Amicus Curiae America's Health Ins. Plans, Inc. et al., in Support of Respondent, Sereboff v. Mid Atl. Med. Servs., 547 U.S. 356 (2006) (No. 05-260), 2006 WL 460877, at *3 n.3 (Feb. 23, 2006). Every dollar blocked from subrogation or reimbursement recovery by an equitable defense is one less dollar for all plan participants to use for their current and future claims.

Moreover, the decision below opens the door to deny enforcement of plan terms used to manage costs beyond those concerning subrogation and reimbursement rights. Plan documents generally include cost management provisions such as beneficiary eligibility requirements, medical provider reimbursement rates and exclusions for non-medically necessary treatments. In situations where plans mistakenly overpay benefits—e.g., for an uncovered person, to a non-credentialed provider, for non-medically necessary treatment, or simply in error—they bring an action under Section 502(a)(3) to enforce plan provisions that reserve the right to

⁹In fiscal year 2000, one of the largest private health care claims recovery services in the United States recovered \$237.3 million in health claims, and had a backlog of over \$1.1 billion of potentially recoverable claims. Motion of the Am. Ass'n of Health Plans et al. For Leave to File a Brief as Amici Curiae and Brief of Amici Curiae in Support of Petitioners, Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002) (No. 99-1786), 2001 WL 487681 at *10, n.20 (May 3, 2001).

recover such overpayments. 10 As it now stands, plans know they can rely on these plan terms to obtain full recovery in these actions. If all of these provisions are at risk of being erased or altered by courts, the size of the plan's fund could shrink even further.

Indeed, the mere risk that such cost management terms could be undermined will cause a reduction in the funds available for other benefits and beneficiaries. For instance, if a plan knows that its exclusion of non-medically necessary cosmetic surgery will be enforced, it can offer better coverage for medically necessary procedures. But if that plan is concerned that it may not be able to recover a mistaken payment for cosmetic surgery, it will need to reserve money to account for that risk—money that would otherwise be available for other benefits.

Put simply, application of equitable defenses would reduce the overall size of the pie for all plan participants.

C. Higher Costs And Lower Recoveries Would Jeopardize Plans' Financial Viability And Result In Reduced Benefits And/Or Higher Out-Of-Pocket Payments For Participants

With higher litigation costs, lower recoveries and less reliable enforcement of other cost management terms, the financial viability of plans will be

¹⁰See, e.g., Kolbe & Kolbe Health & Welfare Benefit Plan v. Med. College of Wis., 657 F.3d 496 (7th Cir. 2011) (Section 502(a)(3) action to recover payment on behalf of an uncovered person); Trustmark Life Ins. Co. v. Univ. of Chicago Hosps., 207 F.3d 876 (7th Cir. 2000) (Section 502(a)(3) action to recover payment for non-medically necessary procedures); Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Neurobehavioral Assocs., P.A., 53 F.3d 172 (7th Cir. 1995) (Section 502(a)(3) action to recover accidental overpayment due to clerical error).

threatened. As a result, plans will be forced to (1) raise participants' premiums/contributions or (2) alter the terms of their plan documents to reduce or delay the payment of benefits.

1. The cost savings generated by predictable rates of subrogation and reimbursement are passed on to plan participants in the form of lower premiums for fully-insured plans, or contributions for self-funded plans. Insurance companies set premiums based on historical net costs and lower costs lead to lower premiums for participants.¹¹ As one scholar has explained:

[I]f the insurer had one hundred policyholders in the experience period, and experienced a total of \$20,000 in claim costs, it will set its actuarial premiums at \$200 per policy holder. If, on the other hand, the insurance company experienced \$20,000 in claim costs and received \$5,000 in subrogation, it will set its actuarial

¹¹ See, e.g., F. Joseph Du Bray, A Response to the Anti-Subrogation Argument: What Really Emerged From Pandora's Box, 41 S.D. L. REV. 264, 273-74 (1996); Bernadette Fernandez, Congressional Research Service, Library of Congress, Health Insurance: A Primer 3 (Feb. 3, 2005) ("The premium generally reflects several factors, including the expected cost of claims for using services in a year, administrative expenses associated with running the plan, and a risk or 'profit' charge"); Zurich Am. Ins. Co. v. O'Hara, 604 F.3d 1232, 1237-38 (11th Cir. 2010) ("Reimbursement inures to the benefit of all participants and beneficiaries by reducing the total cost of the Plan. If O'Hara were relieved of his obligation to reimburse Zurich for the medical benefits it paid on his behalf, the cost of those benefits would be defrayed by other plan members and beneficiaries in the form of higher premium payments"), cert. denied, 131 S. Ct. 943 (2011); Admin. Comm. of Wal-Mart Stores Assocs.' Health & Welfare Plan v. Shank, 500 F.3d 834, 838 (8th Cir. 2007) ("Shank would benefit if we denied the Committee its right to full reimbursement, but all other Plan members would bear the cost in the form of higher premiums").

premiums at \$150 per policy holder. (Who Eats Last?, 64 U. CHI. L. REV. at 1355)

Taking this hypothetical one step further, assume—as relevant here—that the insurance company experienced \$20,000 in claim costs but was forced to spend more (say \$500) in litigation fees to recover less (say \$4,000) in subrogation or reimbursement. In this situation, the premiums would go up from \$150 to \$165 per policy holder.

This effect is amplified in self-funded plans. Fully-insured plans calculate premiums on a state-or nation-wide basis. A self-funded plan has a much smaller risk pool of members. Accordingly, funds returned to a self-funded plan have an even more dramatic effect on historical net costs—and higher litigation costs and lower recoveries will have an even more dramatic effect on their future contribution rates.

For good reason, Congress preempted all state laws that relate to self-funded employee benefit plans in order to protect self-funded plans from the varying state laws that would create uncertainty, drive administrative costs up and reduce subrogation recoveries. As this Court has explained, in enacting ERISA, Congress intended

to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government..., [and to prevent] the potential for conflict in substantive law... requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. (Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990))

If courts could use equitable principles to rewrite unambiguous plan terms, their application of equitable defenses would undoubtedly differ from jurisdiction to jurisdiction (and even court to court), thereby frustrating Congress' purpose in preempting state laws and, ultimately, causing participants to face higher out-of-pocket payments.¹²

2. ERISA does not require that an employer provide any particular benefits. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983). And "employers... are generally free under ERISA, for any reason at any time, to adopt, modify or terminate welfare plans." Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 78 (1995). Accordingly, if plan subrogation and other cost management provisions cannot be fully enforced, plan sponsors may be forced to amend their plans to alter the provisions concerning payment of benefits for which third parties might be liable. That effect would

plans, where state law doctrines like the common fund and made whole doctrine frequently apply. In 2011, premiums for single workers were 3.3% higher in fully-insured versus self-funded plans (\$5,324 versus \$5,499); for families, premiums were 7.3% higher (\$14,434 versus \$15,492). See Employer Health Benefits at 26-27.

applies to self-funded plans, these plans are specifically exempted from some notable requirements, including providing coverage with minimum essential benefits. See Kathryn Linehan, Self-Insurance and the Potential Effects of Health Reform on the Small-Group Market, National Health Policy Forum (Dec. 20, 2010), available at http://www.nhpf.org/library/details.cfm/2839; Christine Eibner et al., Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA), RAND Health (2011), available at http://www.rand.org/pubs/technical_reports/TR971.html.

redound to the detriment of plan participants as a whole.

In order to offset escalating costs and lower recoveries associated with the availability of equitable defenses, plan sponsors will need to either increase participant costs or reduce benefits. They could well defer or delay payment of claims for medical expenses related to third party negligence until the accident liability issues have been resolved completely or until third party litigation has concluded. See, e.g., Kress v. Food Employers Labor Relations Ass'n, 391 F.3d 563, 568 (4th Cir. 2004) (noting that "it makes little sense to argue that ERISA precludes imposing conditions on the receipt of benefits that are in effect an interest-free loan").

Alternatively, to combat the uncertainty that comes with the risk of the use of equitable defenses, plans could choose to secure the certainty of recovery by amending plans to offset future benefits. In other words, a plan could amend an existing subrogation provision to permit the fiduciary to deny future benefits equal to the amount of money that should have been subrogated under the terms of the plan. See, e.g., McIntyre v. Carpenters Health & Sec. Trust, No. C05-5724FDB, 2006 WL 118249, at *9 (W.D. Wash. Jan. 13, 2006) ("Nothing required [the plan participant] to accept the reimbursement option; she was free to reject the advancement of benefits. But where she did accept the advanced benefits offer, and then recovered against the third party, it was not wrongful for the Trust to seek to recoup the advanced benefits and to cease making further advancements"). Or, more drastically, employers might be compelled to amend their plans to exclude entirely coverage for medical expenses related to negligent third party claims. See, e.g., Kress, 391

F.3d at 568 (noting that "third-party accident and sickness benefits are not even covered by the Fund,

nor required by ERISA").

This result, which would negatively impact all plan participants, would also be contrary to a primary goal of Congress in enacting ERISA—to encourage employers to offer the most comprehensive benefits possible by assuring a "predictable set of liabilities" and "a uniform regime" of remedies. Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 379 (2002).

The decision below should be reversed to ensure that employer-sponsored plans remain financially viable and able to cover all of their participants' claims without increasing premiums/contributions.

П.

ALLOWING COURTS TO VARY UNAMBIGUOUS PLAN TERMS WOULD CREATE PERVERSE INCENTIVES THAT UNDERMINE THE PURPOSES OF SUBROGATION

The Third Circuit appears to have been troubled by the prospect that plan participants may be required to reach into their own pockets to repay plans. Pet. App. 16a.¹⁴ It is, however, extremely rare

[&]quot;As noted above, the Third Circuit apparently believed that McCutchen's net recovery was less than US Airways' lien. See note 7, supra. But this is not established in the record. Id. The Third Circuit also stated that the plan would receive a "windfall" if permitted to seek reimbursement because the District Court required McCutchen to provide full reimbursement to the plan even though the plan did not exercise its subrogation rights or contribute to the cost of obtaining third party recovery. Pet. App. 16a. However, it is unclear how the majority rule—which merely suggests that courts should (... continued)

that a plan participant would ever be called upon to reimburse the plan's equitable lien from his own assets. To understand why—and to prevent this unique bad fact from driving bad law—it is useful to understand how subrogation/reimbursement claims generally proceed.

Once a plan determines that claims are related to an accident, the plan notifies the member and his or her attorney of the member's contractual obligation to reimburse the plan, and the plan further notifies the potentially at-fault party and his or her liability insurance carrier that the plan has a subrogation claim with respect to any right to recovery. The plan then monitors the injured party's claim, provides claims information and legal support for the plan's position to the member and at-fault party, and in some instances, intervenes in the plan's name in underlying personal injury action as a third party plaintiff. Amic's preferred method of recovery is to recover the amount it paid in benefits to the member directly from the at-fault party. However, plans routinely negotiate resolution of claims with the member or his counsel. In this way, the plan can balance the interests of the individual participant and the other members to help reach a result that is fair and equitable for all interested parties. 15

⁽Continued . . .)
enforce the reimbursement provision as written in the plan—
would give the plan a "windfall." "Windfall" means unearned
money, and enforcing a provision that protects a plan's assets
cannot, by definition, be a windfall.

¹⁵The plan and the participant have a common interest in the success of an action against the at-fault party—and in facilitating a settlement when that is the best option for maximizing recovery. Plans can, and frequently do, agree to compromise the amount of their liens in order to facilitate a settlement that is beneficial to all plan participants and responsive to the facts of the particular case. The decision below (... continued)

If the unusual situation of a plan seeking reimbursement from the participant's personal assets arose here, it arose only because—with full knowledge of his pre-existing obligation to reimburse US Airways for benefits paid in the event he recovered from a third party-McCutchen (1) agreed to a 40% contingency fee arrangement with his attorneys and (2) agreed to a \$10,000 settlement with the third party tortfeasor and \$100,000 in underinsured motorist coverage without first informing US Airways of the larger of the two settlements. JA 41. 58. If US Airways had been kept fully informed, the plan could have attempted to negotiate for a larger share of the third party tortfeasor's insurance limits, intervened in the action against the third party tortfeasor to pursue its rights in subrogation or agreed to an acceptable compromise on its potential lien.

But if equitable defenses can reduce a plan's lien, plan participants have an incentive to exclude plans from negotiations and attempt to structure their settlements in a manner that precludes plans from exercising their repayment rights—e.g., by allocating the majority of settlement funds to a spouse for loss of consortium. See Aetna Life Ins. Co. ex rel. Lehman Bros. Holdings, Inc. v. Kohler, No. C 11-0439 CW, 2011 WL 5321005, at *5 (N.D. Cal. Nov. 2, 2011) (rejecting the application of equitable defenses and the plan participant's efforts "to allocate the bulk of the money to [his wife for loss of consortium] and a small amount to [himself] in a transparent attempt to circumvent [the plan's] right to recover treatment

⁽Continued . . .) substitutes post hoc reformation of the contract by the court for the individualized determinations of the parties, that is, it interjects judicial decision-making into a process best resolved by the parties.

costs"). That gamesmanship undermines a primary purpose of subrogation, which is to "place the burden for a loss on the party ultimately liable or responsible for it and...relieve entirely the insurer...who indemnified the loss and who in equity was not primarily liable for the loss." Gary L. Wickert, The Societal Benefits of Subrogation, available at http://www.mwl-law.com.

In sum, there is no evidence that the current process is inadequate. To the contrary, plans work efficiently and equitably in a predicable system. And although individual participants, like McCutchen, may occasionally benefit if the decision below is affirmed, millions of other plan participants will suffer: increased costs and decreased recoveries will jeopardize plans' financial viability and the application of equitable defenses will incentivize gamesmanship and lead to unpredictable results.

CONCLUSION

The judgment of the Third Circuit should be reversed.

Respectfully,

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September 5, 2012.

AMICUS CURIAE BRIEF

IN THE

Supreme Court of the United States

U.S. AIRWAYS, INC. in its capacity as Fiduciary and Plan Administrator of the U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN, Petitioner.

1

JAMES E. McCUTCHEN AND ROSEN, LOUIK & PERRY, P.C.,

V.

Respondents.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Third Circuit

BRIEF OF AMICUS CURIAE CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND IN SUPPORT OF PETITIONER

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INTEREST OF AMICUS CURIAE

The Central States, Southeast and Southwest Areas Health and Welfare Fund ("Central States" or the "Fund") respectfully submits this brief as amicus curiae in support of the petitioner, U.S. Airways, Inc. The parties have filed a blanket consent to the filing of amicus curiae briefs with the Court.

Central States is a multiemployer employee welfare benefit plan as that term is defined in Section (3)(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1002(1). See Central States, SE & SW Areas Pension Fund v. Central Transport, Inc., 472 U.S. 559, 561-562 (1985). Central States is a non-profit, tax qualified, Taft-Hartley trust, administered by eight trustees, four appointed by contributing employers and four elected by the unions whose members are participants and beneficiaries of the Fund. See 29 U.S.C. § 186.

Central States provides medical, hospital, dental, vision, life and disability benefits to more than two hundred and forty thousand covered employees and their dependents who reside in forty-nine states, the District of Columbia and Puerto Rico. Central States is self-funded and pays benefits directly from the

In compliance with Rule 37 of this Court, counsel for Central States represents that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus*, its employees, or its counsel made a monetary contribution to the preparation or submission of this brief.

contributions it receives from participating employers. As noted above, Central States is a not-for-profit trust, and its assets are used exclusively to provide benefits for participants and beneficiaries and to defray the reasonable costs of administering the benefit plan. See 29 U.S.C. § 1104(a)(1)(A).

The participants in Central States work for employers who have entered into collective bargaining agreements with the International Brotherhood of Teamsters (IBT) or work for IBT local unions that have agreed in writing to contribute to the Fund. These agreements require employers to pay a certain level of contributions to Central States in return for a set benefit plan offered by the Fund for that particular contribution level. Each contributing employer executes a participation agreement with Central States agreeing, among other things, to pay the required contributions and to abide by a Trust Agreement and all the rules and regulations set by Central States' Trustees who administer the Fund. Central States is administered pursuant to the terms of the Trust Agreement and the benefits provided by the Fund are detailed in a Plan Document.

Like most health plans, Central States' Trustees have implemented prudent measures to control and recover costs, including the adoption of subrogation and reimbursement provisions. See 29 U.S.C. § 1104(a)(1)(B). These subrogation and reimbursement provisions, in summary, grant the Fund immediate subrogation rights to all present and future rights of a covered individual to recover for injuries resulting in medical treatment covered by the Fund. That is, the Plan Document grants Central States an immediate assignment of a covered

individual's loss recovery rights to the extent it pays any benefits on behalf of the individual relating to his or her injury or disability. Pursuant to the Plan Document, a covered individual may not make a settlement or other distribution of his loss recovery rights without the written consent of Central States and any settlement shall not relieve the covered individual of his or her obligation to reimburse Central States the full amount of its subrogation rights. The Plan Document further provides that Central States is not financially responsible for any expenses, including attorneys' fees, incurred on behalf of the covered individual in the enforcement of his loss recovery rights. except as expressly authorized by the Fund. Trustees are vested with discretionary and final authority in making decisions that interpret plan documents relating to subrogation. The Plan Document also provides that whenever the Fund has made benefit payments which exceed the amount of the benefits payable under the terms of the Plan, the Fund shall have the right to recover excess payments from any responsible person or entities. A recent internal audit disclosed that, pursuant to these subrogation and reimbursement provisions, Central States has realized gross recoveries and savings in excess of \$133.5 million since the inception of its present subrogation program in 1984. Annual gross recoveries from this program during the past ten years (2002-2011) have averaged \$5.7 million with a high of \$7.03 million in 2011.

Contribution rates and corresponding benefit levels for employers who contribute to Central States on behalf of their covered employees, and deductibles and co-payments, are set by the Trustees after consultation with actuaries who rely upon vari-

ous assumptions, one of which is the assumption that the Fund will be administered pursuant to the terms of its Plan Document. One of the key actuarial assumptions is that the subrogation and reimbursement provisions of the Plan (along with all other Plan terms) will be consistently applied and enforced as written. Recoveries under the subrogation and reimbursement provisions of the Plan are thus necessary to properly and predictably set contribution rates needed to fund the benefit levels stated in the various benefit plans offered by Central States. As noted above, the contribution rates paid to Central States by participating employers are set forth in collective bargaining agreements entered into between these employers and affiliates of the IBT. Therefore, Central States cannot unilaterally increase contribution rates and because these collective bargaining agreements typically cover periods of three years, it is impossible for the Fund to quickly adjust contribution rates to account for the loss of anticipated revenue and unanticipated expenses. If subrogation and reimbursement recoveries are reduced, benefits provided to beneficiaries may need to be correspondingly reduced to preserve plan assets, and eventually, contribution rates will need to be increased.

The resolution of the issues in this case will have a significant impact not only upon Central States, but upon the administration of other self-funded, multi-employer employee welfare benefit plans which rely upon similar subrogation and reimbursement rules set forth in plan documents. If the decision below is not reversed, such plans will not be able to rely on their plan provisions relating to subrogation and reimbursement because the Third Circuit's decision

authorizes courts to ignore the application of such rules on a case by case basis. The resolution of this case also has a substantial impact upon such plans in that, if the Third Circuit's opinion is not reversed, legal expenses incurred by Central States and all similar plans will increase dramatically, further eroding the financial stability of such plans.

SUMMARY OF THE ARGUMENT

Central States seeks to bring to the Court's attention the negative impact which the Third Circuit's decision will have on self-funded multiemployer employee welfare benefit plans, particularly those whose beneficiaries reside in many different states. This decision renders it impossible for such plans or their beneficiaries to rely on the terms of their written plan documents, makes setting rates a guessing game, significantly increases such plans' administrative costs and ensures a sharp increase in litigation. In so doing, the Third Circuit's opinion undermines ERISA's goals of ensuring uniformity and predictability in plan administration and in preserving the financial integrity of employee benefit plans.

ERISA's statutory scheme is built around reliance on the face of written plan documents. The Third Circuit's opinion runs contrary to this mandate by authorizing courts to rewrite plan documents whenever they determine that it would be inequitable to enforce the unambiguous plan terms as written. The Third Circuit's opinion, however, is flawed in several respects. First, the opinion ignores the fact that Section 502(a)(3) of ERISA does not authorize "appropriate equitable relief" at large, but only for the purpose of enforcing any provision of ERISA or

the plan. The Third Circuit's opinion does the opposite. It authorizes courts to fashion equitable defenses for the specific purpose of disregarding the express terms of the plan. This is inconsistent with ERISA's explicit requirement that plans be enforced as written which fosters Congress' goals of providing certainty for participants and beneficiaries as well as plan administrators and ensuring uniformity in the regulation and funding of such plans.

The Third Circuit also incorrectly concluded that it would "undermine the entire purpose of the plan" to allow the plan to recover from McCutchen because it would leave him with less than full payment for his medical bills. However, plan trustees are required to discharge their duties taking account the interests of all beneficiaries of the plan. Moreover, ERISA was not intended to assure full payment for all medical bills, but to assure full payment of benefits promised under the written plan terms (which in this case also includes reimbursement provisions). And, the Third Circuit's opinion incorrectly favors the interests of one individual beneficiary at the expense of all of the plan's other beneficiaries. Finally, the court's reliance on this Court's opinion in CIGNA Corp. v. Amara, ___U.S. ___, 131 S.Ct. 1866 (2011), as authority for its ruling is also misplaced as that decision does not authorize the reformation of plan documents in all circumstances, but instead limited this extraordinary relief to situations involving fraud. Because no fraud is present in the McCutchen case, CIGNA Corp. does not support the Third Circuit's reformation of the relevant plan document.

The McCutchen decision also runs afoul of another

of ERISA's stated goals by threatening the financial integrity of employee welfare benefit plans. Reimbursement and subrogation provisions are crucial to the financial viability of self-funded ERISA Because benefit levels and corresponding rates are based upon actuarial assumptions which assume a certain predictable level of subrogation and reimbursement recoveries, such recoveries are necessary to fund the benefit levels stated in the various plans offered. The Third Circuit's opinion ensures that such recoveries will be reduced and makes it virtually impossible for the Fund's actuaries to predict what these recoveries will be. As a result, there is an increased risk that the rates set by Central States may ultimately be insufficient to pay for the corresponding benefits level leaving the fund with a deficit. Exacerbating this problem is the fact that because the contribution rates paid to Central States (as well as other multiemployer plans) are incorporated into collective bargaining agreements which are typically three years in duration, the Fund has no way of quickly increasing contributions to make up for any shortfalls.

Finally, the Third Circuit's opinion further threatens the financial integrity of employee benefit welfare plans by opening the floodgates of litigation with such plans. Because the opinion invites courts to evaluate the equities on a case-by-case basis, it is a certainty that litigation costs will increase dramatically. Since each dollar spent in litigation costs is a dollar unavailable to pay benefits, this further threatens the financial integrity of employee welfare benefit plans.

ARGUMENT

- I. ALLOWING COURTS TO USE EQUITABLE PRINCIPLES TO REWRITE CONTRACTUAL PLAN LANGUAGE REQUIRING PARTICIPANTS TO REIMBURSE EMPLOYEE WELFARE BENEFIT PLANS FOR BENEFITS PAID WOULD FRUSTRATE THE POLICIES UNDERLYING ERISA AND THREATEN THE FINANCIAL INTEGRITY OF SUCH PLANS.
 - A. The Third Circuit's Decision Is Inconsistent With ERISA's Goal Of Ensuring Uniformity And Predictability In Plan Administration And Funding.

In enacting ERISA, Congress recognized that because the continued well-being and security of millions of employees and their dependents are directly affected by employee benefit plans, such plans are affected with a national public policy interest. 29 U.S.C. § 1001(a). Accordingly, one of the stated goals in enacting ERISA was to protect the financial soundness of such plans. *Id.* Congress further stressed the importance of uniform federal regulation of such plans and the need to protect contractually defined benefits. *Id.*

Both ERISA's legislative sponsors and this Court have emphasized the necessity for uniform federal regulation of not only the substantive provisions of the statute, but also the enforcement provisions applicable to ERISA plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983) (quoting 120 Cong. Rec. 19933 (1974));

See also FMC Corp. v. Holliday, 498 U.S. 52, 60 (1990). As this Court has recognized, one of ERISA's primary policies is to induce employers to offer benefits "by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 379 (2002) (citations omitted). To achieve this objective ERISA requires that "every employee benefit plan shall be established and maintained pursuant to a written instrument" and mandates that named fiduciaries control and manage the operation and administration of the plan. 29 U.S.C. § 1102(a)(1). Further, each trustee has a fiduciary duty to "discharge his duties inaccordance with the documents and instruments governing the plan. . . . " 29 U.S.C. § 1104(a)(1)(D). The courts have consistently emphasized the primacy of plan provisions absent a conflict with the statutory policies of ERISA. Admin. Comm. of Wal-Mart Stores, Inc. v. Varco, 338 F.3d 680, 691-92 (7th Cir. 2003) (citing cases). The Third Circuit's opinion runs directly contrary to these congressional mandates by authorizing courts under the rubric of equity to rewrite plan documents and ignore unambiguous plan terms thus undermining the very uniformity and reliance upon such documents which Congress sought to ensure in enacting ERISA.

ERISA's enforcement provision specifically provides that a civil action may brought:

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equi-

table relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan.

29 U.S.C. § 1132(a)(3). This Court has directed that when courts consider the meaning of "appropriate" equitable relief as used in this provision, they should "keep in mind the special nature and purpose of employee benefit plans." Varity Corp. v. Howe, 516 U.S. 489, 515 (1996). One of the repeatedly emphasized purposes of ERISA is to protect and ensure the financial integrity of contractually defined benefits. Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985); Admin. Comm. of Wal-Mart Stores, Inc. v. Shank, 500 F.3d 834, 838 (8th Cir. 2007). In light of these directives, courts have been reluctant to authorize the use of common law equitable defenses to alter the express terms of a written plan.

This Court in Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356 (2006), specifically held that employee benefit plans can enforce reimbursement and subrogation provisions under 29 U.S.C. § 1132(a)(3) because such provisions establish an equitable lien by agreement. Left open by this decision, however, was the question of whether plan participants can utilize equitable defenses to defeat unambiguous reimbursement and subrogation provisions. Prior to the Third Circuit's opinion in McCutchen, all the courts of appeal that considered this issue declined to read Section 502(a)(3) of ERISA as allowing equitable defenses and uniformly held that unambiguous subrogation provisions contained in plan documents should be

enforced as written.2 These courts correctly recognized that Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), "does not authorize 'appropriate equitable relief at large, but only 'appropriate equitable relief' for the purpose of...'enforci[ng] any provisions' of ERISA or an ERISA plan." Shank, 500 F.3d at 838, citing Mertens v. Hewitt Assoc., 508 U.S. 248, 253 (1993). (emphasis in original).3 This is the critical point which the McCutchen court misses. The term "appropriate equitable relief" is limited in the statute in that it can only be utilized for the purpose of enforcing the provisions of ERISA or the terms of the plan. The Third Circuit's opinion does the opposite. It authorizes courts to fashion equitable defenses in order to disregard the terms of the This runs counter to ERISA's repeatedly emphasized purposes of protecting contractually defined benefits, providing for a uniform set of regulations and securing the financial integrity of employee benefit plans.

See Zurich Am. Ins. Co. v. O'Hara, 604 F.3d 1232 (11th Cir. 2010); Admin. Comm. of Wal-Mart Stores, Inc. v. Shank, 500 F.3d 834 (8th Cir. 2007); Admin. Comm. of Wal-Mart Stores, Inc. v. Varco, 338 F.3d 680 (7th Cir. 2003), Bombardier Aerospace Emp. Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough, 354 F.3d 348 (5th Cir. 2003). See also Admin. Comm. of Wal-Mart Stores, Inc. v. Wells, 213 F.2d 398 (7th Cir. 2000).

³ On June 20, 2012 the Ninth Circuit adopted the *McCutchen* holding in *CGI Tech. & Solutions*, *Inc. v. Rose*, 683 F.3d 1113 (9th Cir. 2012), thus deepening the circuit split.

The Third Circuit in McCutchen held that the plan was seeking relief which was not "appropriate equitable relief" as that term is used in 29 U.S.C. § 1132(a)(3). The Court reasoned that the judgment constituted "inappropriate and inequitable relief" because the amount of the judgment exceeded the net amount of McCutchen's third-party recovery. U.S. Airways, Inc. v. McCutchen, 663 F.3d 671, 679 (3rd Cir. 2011). The Court held that allowing such a recovery would "undermine the entire purpose This reasoning, however, is of the Plan." Id.flawed in several respects, particularly when applied to multiemployer welfare benefit plans such as Central States. First, it ignores the fact that the unambiguous plan language providing for reimbursement and subrogation established, as this Court in Sereboff recognized, an equitable lien by agreement. Such plan language confers benefits on both parties, not just the plan. In exchange for promising to reimburse the plan from any third party recoveries, the participant receives the certainty that the plan will pay his/her medical bills immediately if they are injured. See generally Admin. Comm. of Wal-Mart Stores. Shank, 500 F.3d 834, 839 (8th Cir. 2007); Admin. Comm. of Wal-Mart Stores, Inc. v. Varco, 338 F.3d 680, 692 (7th Cir. 2003). The Third Circuit's opinion completely ignores the parties' equitable lien by agreement. Instead, it allows one party (the participant) to reap the benefit of the agreement but deprives the other party (the plan) of its side of the bargain. Contrary to the Third Circuit's reasoning, the recovery sought by the plan was entirely consistent with the plan's purpose and

design and simply sought to enforce the parties' agreement.

It also bears noting that if Third Circuit's opinion is allowed to stand, multiemployer plans will be forced to reconsider their policies of advancing payment for medical bills related to injuries sustained in accidents. If benefit plans cannot rely upon the consistent and uniform enforcement of their subrogation rights, and in order to avoid having one employer subsidize the benefits of another employer's employees, multiemployer plans could add plan provisions to exclude from coverage claims related to accidents or simply delay paying such claims. However, the prompt payment of medical expenses by Central States benefits all of the Plan's beneficiaries because the Fund has contracted with medical service providers for substantial discounts in exchange for prompt If the plan is modified to exclude or delay payment for claims related to accidents, it would result in the loss of these discounts afforded to the plan (and its participants) for prompt payment. Although such a course of action would potentially compensate for lost subrogation and reimbursement recoveries, this added layer of administration would delay payment of a beneficiary's benefits, subject the beneficiary to collection efforts from unpaid providers, increase the cost of medical coverage and increase the cost of administering the plan.

The McCutchen court also incorrectly held that it was appropriate to reform the plan under the guise of equitable reformation. As authority for this holding,

the Third Circuit cited this Court's decision in CIGNA Corp. v. Amara, for the proposition that:

... the importance of the written benefit plan is not inviolable, but is subject based upon equit-able doctrines and principles - to modification and, indeed, even equitable reformation under § 502(a)(3).

U.S. Airways, Inc. v. McCutchen, 633 F.3d at 678 citing CIGNA Corp. v. Amara, ___ U.S. ___, 131 S.Ct. 1866, 1879 (2011). The Third Circuit, however, is reading CIGNA Corp. in an overly expansive fashion. In CIGNA, this Court recognized that the traditional power of an equity court to reform contracts is a power that was used to prevent fraud. The Court did not authorize the reformation of plan documents for any other reason. Id. CIGNA Corp. is consistent with the well settled rule that a court of equity cannot change the terms of a contract absent fraud, accident or mistake. Mfrs' Finance Co. v. McKey, 294 U.S. 442, 449 (1935). The Third Circuit's reading of CIGNA as carte blanche authority for courts to rewrite the unambiguous terms of ERISA welfare benefit plans whenever they feel it would be inequitable to enforce the terms as written, is simply erroneous.

As noted above, the Third Circuit concluded that requiring McCutchen to provide full reimbursement to the plan would constitute inappropriate and inequitable relief because it would leave McCutchen with less than full payment of his medical bills. U.S. Airways v. McCutchen, 663 F.3d at 679. The Court reasoned that this would undermine the entire purpose of the plan. Id. This analysis mis-

construes the purpose of such plans and the duties of plan trustees. The trustees of such plans are required to discharge their duties solely in the interest of all of the participants and beneficiaries of the plan. 29 U.S.C. § 1104(a). Although McCutchen himself will be a better position if the Third Circuit's opinion is allowed to stand, the interests of all other members of the plan will be jeopardized. Reimbursement pursuant to a plan's subrogation and reimbursement provisions inures to the benefit of all participants and beneficiaries of the plan by reducing the total cost of the plan. If McCutchen is relieved of his obligation to reimburse the plan, the costs of those benefits will be borne by other members of the plan in the form of higher premium payments or reduced benefits. As noted, plan trustees are required to discharge their duties by taking impartial account of the interests of all beneficiaries of the Plan. Varity Corporation v. Howe, 516 U.S. 489, 514 (1996). The Third Circuit's opinion improperly favors the interests of one individual beneficiary at the expense of all of the plan's other participants and beneficiaries. Because the ruling is based upon a flawed interpretation of fiduciary duties and is inconsistent with ERISA's purposes of protecting contractually defined benefits and providing for uniformity of regulation, it should be reversed.

B. The Third Circuit's Decision Is Inconsistent With ERISA's Goal Of Protecting The Financial Integrity Of Employee Welfare Benefit Plans.

Central States, like many employee welfare benefit

plans, contains subrogation language in its plan document which requires a beneficiary who is injured as a result of an act or omission of a third party to reimburse the plan for benefits it pays on account of those injuries, if the beneficiary recovers for those injuries from a third party. Such reimbursement and subrogation provisions are important to the financial viability of self-funded ERISA plans. Central States, for example, has achieved gross recoveries and savings totaling in excess of \$133.5 million since the inception of its present subrogation and reimbursement program in 1984. Gross recoveries from this program during the past ten years have averaged \$5.7 million per year with a high of \$7.03 million in 2011. Since contribution rates are based on actuarial assumptions which assume a certain and predictable level of subrogation and reimbursement recoveries, these recoveries are necessary to provide assets sufficient to fund the benefit levels stated in the various benefit plans offered by Central States. If the Third Circuit's opinion is not reversed, subrogation and reimbursement recoveries will obviously be reduced. In addition, it will be difficult, if not impossible, for Central States' actuaries to predict with any degree of certainty what those recoveries will be. As a result, the contribution rates set by the Fund may not be sufficient to pay for the corresponding benefit level leaving the Fund with a deficit. Moreover, as noted earlier, the contribution rates paid to Central States by participating employers are set forth in collective bargaining agreements entered into between these employers and affiliates of the IBT. Thus, Central States cannot unilaterally increase rates, and because these agreements typically cover periods of three years, it is impossible for the Fund to quickly adjust

rates to account for the loss of anticipated revenue and unanticipated expenses. As a result, if subrogation and reimbursement recoveries are reduced resulting in the rates not supporting the corresponding benefit level, benefits provided to beneficiaries may need to be correspondingly be reduced to ensure that the Fund has sufficient assets to pay its obligations and eventually, contribution rates will need to be increased. There can be no question that the negative impact of the Third Circuit's decision on Central States and other large multiemployer welfare benefit plans, as well as their beneficiaries, will be substantial.

The Third Circuit's opinion will also introduce uncertainty and significant litigation costs into plan administration. Instead of ensuring ERISA's policy of uniform enforcement of employee benefit plans in accordance with the plain meaning of the plan's terms, the decision below will have the opposite effect. Large multiemployer welfare benefit plans such as Central States will have absolutely no ability to predict with any degree of certainty how its plan will be enforced. Because the Third Circuit's opinion authorizes courts to enforce or modify a plan's subrogation language on a case by case basis, based upon each court's subjective notion of what is "appropriate" under the circumstances, Central States' contractual plan language will be enforced against some beneficiaries in one region of the country but not against others who live somewhere else. Of course, because the outcomes in each instance are impossible to predict, the actuarial assumptions underlying the setting of rates and benefit levels will be difficult to develop and rely upon. Needless to say, such a scenario places a heightened risk on the financial integrity of such plans.

In addition to the uncertainty and financial risks inherent in the Third Circuit's decision, there will also be a major increase in litigation costs associated with the administration of employee welfare benefit plans as the decision will open the floodgates of litigation with such plans. Because the Third Circuit's opinion invites courts to evaluate the "equities" of each case, regardless of unambiguous contractual plan language, it is a certainty that litigation costs will rise exponentially. As one district court recently recognized in criticizing the Third Circuit's opinion:

For each person whom a court in "fairness" allows to skip repayment, there will blossom many lawsuits from others who aspire to skip re-payment (and why not; they may get lucky; under *McCutchen*, all depends - the ERISA plan aside - on the contingency of a court's conscience). The losers again, are the other beneficiaries.

Schwade v. Total Plastics, Inc., 837 F.Supp.2d 1255, 1278 (M.D. Fla. 2011). The addition of such uncertainties and additional litigation will significantly increase the costs of employee welfare benefit plan administration.

C. The Third Circuit's Opinion Is Inconsistent With ERISA's Goal Of Encouraging Resolution Of Benefits Disputes Through Internal Administrative Proceedings Rather Than Through Litigation

Consistent with ERISA's goals of uniformity of interpretation and ensuring the financial integrity of plans discussed above, ERISA encourages the resolution of benefits disputes through internal administrative proceedings rather than through time consuming

and costly litigation. Conkright v. Frommert, ____ U.S. ___, 130 S.Ct. 1640, 1649 (2010). In determining the proper standard of review to be applied to decisions of ERISA plan administrators, this Court has determined that if the trust documents grant the trustees the power to construe disputed or doubtful terms, the trustees' interpretation will not be disturbed as long as it is reasonable. Firestone Tire and Rubber Company v. Bruch, 489 U.S. 101, 111 (1989). As this Court has noted, this deferential arbitrary and capricious standard of review:

... promotes efficiency by encouraging resolution of benefits disputes through internal administrative proceedings rather than costly litigation. It also promotes predictability, as an employer can rely on the expertise of the plan administrator rather than worry about unexpected and inaccurate plan interpretations that might result from de novo judicial review. Moreover, *Firestone* deference serves the interest of uniformity, helping to avoid a patchwork of different interpretations of a plan. . .

Conkright, 130 S.Ct. at 1649.

This deferential standard of review is particularly appropriate when applied to multiemployer welfare benefit plans, such as Central States, which are not for profit trusts that are administered by boards of trustees composed equally of representatives of labor and management. Because of these attributes, the trustees of such plans act with no conflict of interest. Thus, the concerns over conflict of interest which are sometimes a concern when an insurance company is both plan administrator and insurer of benefits, or when the employer is the administrator

of a self-funded single-employer plan, are not present with not for profit multiemployer welfare benefit plans. When such plans pay the medical expenses of a participant or beneficiary who is injured in an accident, and the participant or beneficiary recovers a settlement or award against a responsible third party, to the extent the trustees seek to recover the full amount of the plan's claim, they are not seeking a windfall for shareholders or investors, but are only seeking to preserve plan assets for the benefit of all of the plan's participants and beneficiaries. Trustees thus discharge their fiduciary duty to administer the plan in strict accordance with the documents and instruments governing the plan as mandated by ERISA. The Trustees also have the benefit of making decisions based on evaluation of their effect on the plan as a whole and all of its participants and beneficiaries. The Third Circuit's opinion, on the other hand, shifts the primary responsibility for plan administration and enforcement from trustees to district courts. Further, the opinion invites courts to evaluate plan enforcement in the vacuum of a single case, without regard for its impact on the plan as a whole. This approach is not consistent with ERISA and places the viability of multiemployer employee welfare benefit plans in jeopardy.

CONCLUSION

It is undeniable that the Third Circuit's decision will have a major negative impact on Central States and other multiemployer employee welfare benefit plans and also upon such plans' participants and beneficiaries. Applying federal common law to override a plan's unambiguous reimbursement and subroga-

tion provisions, as authorized by the Third Circuit, undermines, rather than effectuates, ERISA's goals of ensuring uniformity and predictability in plan administration and in preserving the financial integrity of employee welfare benefit plans. The decision also opens the floodgates of litigation for employee welfare benefit plans further eroding plan resources. For these reasons, Central States respectfully requests that this Honorable Court reverse the decision of the Third Circuit in this case.

Respectfully submitted,

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AMICUS CURIAE BRIEF

IN THE

Supreme Court of the United States

U.S. AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the U.S. AIRWAYS, INC.

EMPLOYEE BENEFITS PLAN,

Petitioner.

V.

JAMES MCCUTCHEN and ROSEN, LOUIK & PERRY, P.C., Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA, AMERICAN BENEFITS COUNCIL, ERISA INDUSTRY COMMITTEE, AND SOCIETY FOR HUMAN RESOURCE MANAGEMENT AS AMICI CURIAE IN SUPPORT OF PETITIONER

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The Chamber of Commerce of the United States of America, the American Benefits Council, the ERISA Industry Committee, and the Society for Human Resource Management respectfully submit this brief as *amici curiae* in support of petitioner.¹

INTERESTS OF AMICI CURIAE

The Chamber of Commerce of the United States of America (the "Chamber") is the world's largest business federation. It represents 300,000 direct members and indirectly represents an underlying membership of more than three million businesses and professional organizations of every size, in every industry sector, and from every geographic region of the country. A principal function of the Chamber is to represent the interests of its members by filing amicus briefs in cases involving issues of vital concern to the nation's business community. Many Chamber members provide health benefits to employees and arrange for the provision of health care services through employee welfare benefit plans regulated under ERISA. The ability of its members to purchase affordable health care coverage for the benefit of their employees is of vital importance to them, their employees, and the employees' dependents, and to the Chamber.

The American Benefits Council ("ABC") is a broad-based nonprofit trade association founded to

¹ No counsel for any party has authored this brief in whole or in part, and no person other than *amici*, their members, or their counsel have made any monetary contribution intended to fund the preparation or submission of this brief. The parties' letters consenting to the filing of this brief have been filed with the Clerk's office.

protect and foster the growth of this Nation's effective and important privately sponsored employee benefit plans under ERISA. The members of ABC include both small and large employer sponsors of employee benefit plans, as well as plan support organizations, such as consulting and actuarial firms, investment firms, banks, insurers and other professional benefit organizations. Collectively, its more than 250 members sponsor, administer or advise plans covering more than 100 million plan participants.

The ERISA Industry Committee ("ERIC") is a non-profit organization representing the Nation's largest employers with ERISA-covered pension, health-care, disability, and other employee-benefit plans. These employers provide benefits to millions of active workers, retired persons, and their families nationwide.

The Society for Human Resource Management ("SHRM") is the world's largest association devoted to human resource management. Representing more than 250,000 members in over 140 countries, the Society serves the needs of HR professionals and advances the interests of the HR profession. Founded in 1948, SHRM has more than 575 affiliated chapters within the United States and subsidiary offices in China and India. SHRM's membership comprises HR professionals who work for employers that sponsor health plans for their employees.

INTRODUCTION AND SUMMARY

For more than 30 years, the Employee Retirement Income Security Act ("ERISA") has encouraged the development of widespread employment-based

coverage for disability, health, and other benefits. ERISA does not require that employers adopt benefit plans, nor does it require that they offer any particular benefits if they do offer a plan. But it does require that employers honor the written terms of whatever benefit plan they decide to offer. ERISA thus places primacy on the written terms of benefit plans. Doing so benefits employers and participants alike; the participants know the benefits to which they are entitled, and employers are ensured a predictable set of liabilities and costs.

The decision below, by upsetting the parties' contractually-defined expectations, is plainly inconsistent with ERISA's text and purpose. Section 502(a)(3) of ERISA authorizes courts to grant "appropriate equitable relief' only to enforce the provisions of ERISA or the terms of the benefit plan. Instead of granting equitable relief that was an "appropriate" means to enforce the terms of the plan, the court below granted equitable relief to rewrite the terms of the plan. In reaching this result, the court below misread (and dramatically expanded) this Court's holding in Cigna Corp. v. Amara, 131 S. Ct. 1866 (2011). Properly understood, Amara simply applies the well-established contract law principle that a contract may be reformed where necessary to reflect the clearly demonstrated mutual understanding of the parties. It thus reinforces, rather than undermines, the well-established ERISA principle that the parties' contractually-defined benefits should be enforced.

The decision below also contravenes ERISA's well-established purposes of promoting the creation of employee benefit plans and protecting the indi-

viduals who participate in those benefit plans. If this Court affirms the decision below, plans or their employer sponsors will incur significant costs litigating equitable defenses on a case-by-case basis. And denial of reimbursement will deplete plan assets, forcing them to compensate by increasing premiums or other costs, or by reducing benefits. The inevitable result of doing "equity" in particularized instances is to harm participants generally, by increasing their costs or reducing their benefits. Given the number of Americans who receive health care through employer-based benefit plans, the adverse consequences will likely be significant.

By contrast, enforcing written plan reimbursement provisions does not produce unjust or inequitable results. It merely enforces a rational and fair contractual bargain. The participant here received a clear benefit (immediate payment of his medical bills), and he knew that in exchange for that benefit he would have to reimburse the plan if he ultimately recovered monies from the third party who was responsible for his injuries. Even if the plan in this case recovered slightly more than the participant's net third-party recovery—a fact that the record does not actually establish-that result is anomalous. It does not provide reason to open a Pandora's box of equitable defenses to enforcement of plan reimbursement provisions, undermining contractual expectations, increasing litigation and administrative costs, and ultimately harming the very employees and beneficiaries ERISA was enacted to protect.

ARGUMENT

I. ERISA PROTECTS EMPLOYEES BY SE-CURING PLAN RIGHTS AND PROMOTING PLAN FORMATION THROUGH THE ES-TABLISHMENT OF UNIFORM REGULA-TION

ERISA was enacted to promote the interests of employees in health and welfare benefit plans in two distinct but related respects.

First, ERISA establishes important contractual and procedural protections for employees of those private employers who choose to establish employee benefit plans. The statute neither compels employers to establish benefit plans nor restricts their freedom to define the benefits they choose to provide. See Lockheed Corp. v. Spink, 517 U.S. 882, 887 (2004) ("Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan."). Employers have "large leeway" to design benefit plans "as they see fit." Black & Decker Disability Plan v. Nord, 538 U.S. 822, 833 (2003). But ERISA does ensure that, if an employer establishes a plan, the participants in the plan have a federal forum and cause of action to enforce the terms of that plan, whatever those terms may be. "There is no doubt about the centrality of ERISA's object of protecting employees' justified expectations of receiving the benefits their employers promise them." Cent. Laborers' Pension Fund v. Heinz, 541 U.S. 739, 743 (2004); see Conkright v. Frommert, 130 S. Ct. 1640, 1648 (2010) ("Congress enacted ERISA to ensure that employees would receive the benefits they had earned"); Lockheed, 517 U.S. at 887 ("Congress . . . wanted to mak[e] sure that if a worker has been promised a defined pension benefit upon retirement—and if he has fulfilled whatever conditions are required to obtain a vested benefit—he actually will receive it" (quotation omitted) (alteration in original)). ERISA's "repeatedly emphasized purpose," in short, is "to protect [the] contractually defined benefits" set forth in the employer's plan. Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985).

The written terms of the plan thus establish the substantive employee rights Congress sought to protect. See Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 83 (1995) (ERISA is "built around reliance on the face of written plan documents"). As the central enforcement action created by ERISA expressly provides, a participant may sue to "recover benefits due to him under the terms of his plan, or to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B) (emphasis added). And as this Court has emphasized, the plan administrator is legally bound to adhere to the written documents governing the plan. Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan, 129 S. Ct. 865, 875 (2009).

Second, in addition to securing participants' contractual rights to whatever benefits their employers choose to provide, Congress sought to "induce[]" employers to offer such benefits, "by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards." Conkright, 130 S. Ct.

at 1649 (quoting Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 379 (2002)); see 29 U.S.C. § 1001a(c)(2) (ERISA enacted "to alleviate certain problems which tend to discourage the maintenance and growth of' employee benefit plans). ing ERISA, Congress recognized "that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities," and that a "patchwork scheme of regulation" causes "considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." Fort Halifax Packing Co. v. Covne. 482 U.S. 1. 11 (1987); see N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 657 (1995) (quoting legislative history). It is thus a central "purpose of ERISA" to reduce administrative costs by "provid[ing] a uniform regulatory regime over employee benefit plans." Aetna Healthcare Inc. v. Davila, 542 U.S. 200, 208 (2004).

ERISA, in sum, balances two complementary objectives: "ensuring fair and prompt enforcement of rights under a plan," on the one hand, and encouraging "the creation of such plans" by reducing the administrative costs and "litigation expenses" associated with disuniform regulation, on the other. *Id.* at 215 (quoting *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (alteration omitted)).

II. IT IS NOT "APPROPRIATE" UNDER § 502(a)(3) TO PROVIDE EQUITABLE RE-LIEF AT ODDS WITH THE PLAN TERMS

This case involves the scope of relief available under § 502(a)(3), the cause of action provided to "enforce" or "redress . . . violations" of ERISA or the plan terms. 29 U.S.C. § 1132(a)(3). Although both beneficiaries and fiduciaries may bring suit under § 502(a)(3), beneficiaries most commonly proceed under § 502(a)(1)(B), the cause of action afforded specifically to beneficiaries to obtain plan benefits or enforce plan rights. *Id.* § 1132(a)(1)(B). Fiduciaries seeking to enforce plan terms are limited to § 502(a)(3), and their remedies under that provision, in turn, are limited to "appropriate equitable relief." *Id.* § 1132(a)(3).

Multiple precedents of this Court have grappled with the meaning of that important phrase. Sereboff v. Mid-Atl. Med. Servs., Inc., 547 U.S. 356 (2006); Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002); Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc., 530 U.S. 238 (2000): Mertens v. Hewitt Assocs., 508 U.S. 248 (1993). This case presents the question whether "equitable relief" in a § 502(a)(3) action may be deemed "appropriate" under this provision when the relief ordered is squarely contrary to the express terms of the plan itself. The answer to that question is no. As shown below, when a court orders equitable relief that overrides the plan terms, that relief contradicts both of the core ERISA objectives discussed above, i.e., protecting employees' contractually-defined rights, and promoting plan formation through uniform regulation.

A. Equitable Relief Under § 502(a)(3) Is Only "Appropriate" If It Is Consistent With The Plan Terms

The phrase "appropriate equitable relief" in § 502(a)(3) does not appear in a vacuum. The relief must be provided only to "redress . . . violations" of ERISA or "the terms of the plan," or to "enforce" ERISA or "the terms of the plan." 29 U.S.C. § 1132(a)(3). There are no freestanding ERISA violations at issue here or in cases like this one-the sole question is what equitable remedy, if any, is "appropriate" to enforce the terms of the plan. Section 502(a)(3) thus on its face commands adherence to the plan terms—the whole point is to enforce plan terms, not override them in the exercise of freewheeling equitable discretion. See Mertens, 508 U.S. at 253 (ERISA "does not, after all, authorize 'appropriate equitable relief at large, but only 'appropriate equitable relief for the purpose of 'redress[ing any] violations or . . . enforcling any provisions' of ERISA or an ERISA plan"); Sereboff, 547 U.S. at 363 ("ERISA provides for equitable remedies to enforce plan terms" (emphasis in original)). As this Court has emphasized, "courts, in fashioning 'appropriate' equitable relief," should "keep in mind the 'special nature and purpose of employee benefit plans,' and respect the 'policy choices reflected in the inclusion of certain remedies and the exclusion of others." Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987). And as discussed above, no "policy choice" in ERISA is more central than Congress's determination that written plan documents must be enforced as written. See supra at 5-6.

The court of appeals in this case turned that principle on its head, holding that straightforward enforcement of the plan terms is the one remedy that would not be "appropriate" here. That holding cannot be squared with § 502(a)(3)'s express emphasis on the plan terms, or with Congress's more general objective of ensuring that employers and employees alike can rely on the plain terms of the plans they agree upon.

The court's holding also finds no support in the precedent on which it principally relies, Cigna Corp. v. Amara, 131 S. Ct. 1866 (2011). As pertinent here, Cigna holds that when an employer or plan fiduciary intentionally misrepresents plan benefits, it may be "appropriate equitable relief" under § 502(a)(3) for the court to reform the plan's written terms to reflect the employer's representations. See id. at 1879 ("reformation of the terms of the plan, in order to remedy the false or misleading information CIGNA provided" was within "a traditional power of an equity court"). Although recognizing that "the basis for the reformation in Cigna was intentional misrepresentations by the employer and fiduciary," the court below read Cigna to stand for the more general point that "the importance of the written benefit plan is not inviolable," despite the precedents and principles discussed above. Pet. App. 15a.

It surely would be surprising if Cigna—without discussion or debate—announced such a dramatic break from this Court's longstanding recognition of ERISA's core objective of enforcing the benefit plan terms. And indeed the decision does no such thing. The Court's emphasis in Cigna on fraud or mistake as the basis for reformation (131 S. Ct. at 1879) was

not merely a happenstance of the facts of that case. Rather, the existence of fraud or mistake was essential to the exercise of reformation in equity. And it was essential for a reason wholly consistent with ERISA's emphasis on protecting employees' contractual expectations: reformation at equity was understood as a means of enforcing the "real" contract as reflected in the parties' communications and actual understanding.

As this Court long ago explained, "[w]here the agreement as reduced to writing omits or contains terms or stipulations contrary to the common intention of the parties, the instrument will be corrected so as to make it conform to their real intent." Moffett, Hodgkins & Clarke Co. v. City of Rochester, 178 U.S. 373, 384 (1900) (quoting Hearne v. Marine Ins. Co., 87 U.S. 488, 490 (1874)). But precisely because the written contract was so important, equity courts would not reform a writing unless the fraud or mutual mistake was "clearly shown." Baltzer v. Raleigh & A.A.L.R. Co., 115 U.S. 634, 645 (1885). "The party alleging the mistake must show exactly in what it consists and the correction that should be made. The evidence must be such as to leave no reasonable doubt upon the mind of the court as to either of these points. The mistake must be mutual It must appear that both have done what neither intended." Moffett, 178 U.S. at 385 (quoting Hearne, 87 U.S. at 490); see Baltzer, 115 U.S. at 645 ("If the proofs are doubtful and unsatisfactory, and if the mistake is not made entirely plain, equity will withhold relief.").

The equitable plan reformation approved in Cigna is thus entirely "appropriate" under

§ 502(a)(3) because it applies only in the exceedingly narrow circumstance where it is clearly shown that the parties mutually understood the plan to provide something other than what its written terms say. In that situation, the remedy advances, rather than contradicts, § 502(a)(3)'s express objective of providing a remedy to "enforce" the "terms of the plan." Cigna decidedly does not enunciate a broader rule that an action to enforce plan terms is subject to any and all defenses to contract enforcement that were generally available in equity. Literally nothing in Cigna suggests such a general principle, which would be directly at odds with ERISA precedents and principles long-settled and not even mentioned in the decision.

When the employer has intentionally misled participants in a Summary Plan Description, or where it is clearly shown that the employer and participants mutually misunderstood the plan, reformation may make sense as a means of vindicating all parties' contractual expectations. But where a court decides, in its own personal exercise of equitable discretion, that a plan term is not fair when applied to one participant, the court is not enforcing the plan or the parties' contractual expectations in any sense. The court instead is simply doing what it thinks is "fair" or "just" for one individual in one situation-and something another court may think is not fair or just for a similarly situated plan beneficiary. Whatever the power of equity courts generally to exercise such authority, courts adjudicating ERISA actions are constrained by the plain language of § 502(a)(3), which restricts equitable relief in circumstances like these to enforcement of "the terms of the plan."

In this case, the governing benefit plan provided for reimbursement of health benefits when there was a subsequent third-party recovery. The decision below improperly negates that express provision.

B. Recognizing Equitable Defenses To Enforcement Of Plan Terms Increases Litigation And Administrative Costs

Enforcing plans as written (absent fraud or mutual mistake) not only protects contractual expectations, it also ensures that plans and employers face "a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards." Conkright, 130 S. Ct. at 1649; see supra at 6-7. "[C]crtainty and predictability are important criteria under ERISA." Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 122 (2008) (Roberts, C.J., concurring). Allowing individual courts to decide for themselves, under the guise of equity, which plan provisions will be enforced and under what circumstances, is squarely at odds with ERISA's objective of establishing uniformity, certainty, and predictability. Plan benefits are not established by equity but by plan terms, which should not be overridden because a court might have provided for different plan benefits and terms.

1. Allowing Any Equitable Exception To Enforcement Of Plan Terms Would Open A Pandora's Box Of Litigation-Increasing Exceptions

The decision below purportedly avoided addressing some equitable defenses to reimbursement, such as the "make whole" doctrine. Pet. App. 9a n.2. But its broad logic encompasses any defense "typically

available in equity" (id. at 9a) and thus invites other courts to apply any and all such defenses.

Numerous different equitable defenses have been asserted over the years to try to defeat enforcement of plan terms on grounds of unfairness or injustice or harshness in individual cases. See, e.g., Admin. Comm. of Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Shank, 500 F.3d 834, 837 (8th Cir. 2007) (asking the court to "apply either the 'makewhole' doctrine or a pro rata share requirement as a rule of federal common law"); Bombardier Aerospace Emp. Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough, 354 F.3d 348, 360-62 (5th Cir. 2003) (asking court to apply "common fund" doctrine); CGI Techs. & Solns. Inc. v. Rose, 683 F.3d 1113, 1119 n.3 (9th Cir. 2012) (invoking a "derivative version of the make-whole doctrine"); Admin. Comm. of the Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Varco, 338 F.3d 680, 692-93 (7th Cir. 2003) (invoking common fund doctrine and doctrine of unjust enrichment). McCutchen himself raised four different potential defenses at various stages of this litigation. Pet. App. 5a, 28a-32a; Appellants' C.A. Br. 16 n.7, 2011 WL 791769 (3d Cir. Feb. 16, 2011). Equity being equity, and lawyers being lawyers, the number and variety of equitable defenses asserted to defeat disagreeable plan terms will surely multiply if the decision below is affirmed.

There is certainly every reason for beneficiaries and their lawyers to be creative in resisting reimbursement. As one court has observed, "they may get lucky"—since "all depends . . . on the contingency of a court's conscience," they may as well refuse to reimburse and see if they draw a judge willing to

conclude that following the plan is just too harrowing to contemplate. Schwade v. Total Plastics, Inc., 837 F. Supp. 2d 1255, 1278 (M.D. Fla. 2012). Litigation will follow as the night follows the day: "For each person whom a court in 'fairness' allows to skip re-payment, there will blossom many lawsuits from others who aspire to skip re-payment" Id.

The broad application of equitable defenses in this context is not a matter of speculation—they are common in the closely related context of insurance subrogation. The court in Swanson v. Hartford Insurance Co., 46 P.3d 584 (Mont. 2002), for example, refused to enforce an unambiguous subrogation clause in an insurance policy, holding that subrogation would not be available "until the insured has been made whole for all losses, as well as costs of recovery." Id. at 588; accord Garrity v. Rural Mut. Ins. Co., 253 N.W.2d 512, 515 (Wis. 1977) (applying "make whole" doctrine to subrogation clause). Other courts have refused to recognize express subrogation provisions on the ground that such provisions represent an invalid assignment of the insured's right to recover against a third-party tortfeasor. See, e.g., Maxwell v. Allstate Ins. Cos., 728 P.2d 812, 814-15 (Nev. 1986); Allstate Ins. Co. v. Druke, 576 P.2d 489, 491 (Ariz. 1978). In reaching this result, one court pronounced subrogation to be a "windfall" for the insurer (Druke, 576 P.2d at 492), even though the policy specifically limited subrogation to the amount of the insurer's payment (id.). Other state courts have rejected such objections and have required subrogation provisions to be enforced according to their plain terms. See, e.g., Hershey v. Physicians Health Plan, 498 N.W.2d 519, 521 (Minn. Ct. App. 1993). Still

other cases have recognized the fact-intensive, individualized nature of equitable defenses to subrogation. See, e.g., Global Int'l Marine, Inc. v. US United Ocean Servs., LLC, 2011 WL 2550624, at *13 (E.D. La. June 27, 2011); Abbott v. Blount Cnty., 207 S.W.3d 732, 735 (Tenn. 2006); Ludwig v. Farm Bureau Mut. Ins. Co., 393 N.W.2d 143, 145 (Iowa 1986).

As experience in the insurance subrogation context shows, it is no exaggeration to say that if an "ungoverned notion of equity" under § 502(a)(3) "becomes pandemic, consistent plan operation becomes impossible, inconsistent judicial ruling becomes commonplace, and some beneficiaries become profiteers at the expense of others." Schwade, 837 F. Supp. 2d at 1279. Applying equitable defenses to enforcement of clear and permissible plan provisions will effectively either undermine the enforcement of legitimate plan provisions or force most subrogation provisions (and perhaps other plan terms) to survive the gauntlet of costly litigation every time they are applied. Allowing courts to make individual judgments about whether and when to follow plan terms thus directly contravenes ERISA's goal of reducing litigation and administrative costs-and thereby promoting plan formation—by ensuring uniform and reasonably predictable regulation. See Zurich Am. Ins. Co. v. O'Hara, 604 F.3d 1232, 1237 (11th Cir. 2010).

2. Equitable Refusal To Enforce Plan Reimbursement Provisions Depletes Plan Assets
And Harms Other Beneficiaries

Equitable refusal to enforce reimbursement provisions also increases plan costs by depriving plans

of assets they would use to pay other claims. Reimbursement allows plans to keep premiums and other participant costs lower than they otherwise would Denial of reimbursement means plans must make up the difference elsewhere, ultimately producing increased costs for other participants or reduced benefits. As this Court has recognized, plans must "preserve assets to satisfy future, as well as present, claims." Varity Corp. v. Howe, 516 U.S. 489, 514 (1996). By shifting the costs of medical expenses that would otherwise be borne by the plan to persons or entities that bear legal responsibility for those expenses, plans are best able to preserve their assets. This, in turn, makes it easier for employers to offer employee benefit plans and to do so at lower costs to participants and beneficiaries. See O'Hara, 604 F.3d at 1237-38; Shank, 500 F.3d at 838.

If courts were to begin applying a wide range of equitable defenses to override express reimbursement provisions, it could significantly reduce employers' anticipated recovery through their reimbursement provisions and increase the costs of offering these plans. Schwade, 837 F. Supp. 2d at 1274 (McCutchen decision is "certain to increase the cost to each participant in each plan"). Under some equitable defenses, plans may be denied reimbursement altogether. Under "make-whole doctrine," for example, a beneficiary who settles with the tortfeasor will be liable to the plan only to the extent the settlement exceeds his total loss. See O'Hara, 604 F.3d at 1236. And beneficiaries will often persuade courts that the tortfeasor settlement did not make them whole, thereby denying the plan any recovery of its medical care payments, even though the settlement compensated for the exact same medical costs. See, e.g., id. at 1234 n.1 ("It is undisputed that [the participant] was not made whole by receipt of the funds under the settlement agreement."); Moore v. CapitalCare, Inc., 461 F.3d 1, 10 (D.C. Cir. 2006) ("It is undisputed that the \$1.3 million settlement did not fully compensate Alistaire for her injuries."). Under other defenses, reimbursement for medical payments may be significantly reduced by claimed attorneys' fees and costs (which can be thirty to forty percent of the beneficiaries' recovery), even if the net recovery still exceeds the amount of reimbursement.

3. Increased Plan Costs Harm Beneficiaries

If the decision below is affirmed, and courts begin opening equitable escape hatches to the enforcement of unambiguous reimbursement provisions and other plan terms, there is little doubt that premiums will increase, or benefits will be reduced, or both. "If a plan cannot trust a court to enforce a subrogation right, a beneficiary cannot receive lower premiums or better benefits in exchange for pledging to re-pay the plan from a tort award or an insurance payment." Schwade, 837 F. Supp. 2d at 1278. Even if courts allow such defenses only occasionally, the significant costs of litigating these defenses will sap resources that would otherwise have gone to paying benefit claims and otherwise undermine the uniform administration of benefit terms.²

² Indeed, even with reimbursement provisions and other cost-saving measures in place, premiums for employer-sponsored health insurance have increased significantly over the past decade. See The Henry J. Kaiser Family Foundation & Health Research & Education Trust, Summary of Findings,

And that is the least of it. Some employers will conclude that they cannot defray the higher costs the decision below will produce simply by passing them onto other participants and beneficiaries. Instead, they will decide that it no longer makes sense to offer a benefit plan or to offer the same level of benefits they currently provide. Thus, some employers may eliminate their plans, or they may reduce benefits to a more cost-effective level.

Other employers may elect to address the reimbursement issue more directly, amending their plans to stop providing payments for medical benefits in cases where a third party is responsible for the underlying illness or injury. Plans provide for the payment of these medical expenses as an important convenience to their participants and to ensure that medical providers are paid in a timely manner. If plan sponsors lack confidence they will be reimbursed if those costs are recovered from the responsible third party, they may stop providing this accommodation and exclude payments for illnesses or injuries for which third parties may be liable. Or they may suspend payment until it is established that the potentially liable third party bears no responsibility for the payments. Participants will be stuck negotiating on their own for medical services, without the assurance of insurer-payment, often at a time when they are physically unable or ill-prepared to do so.

Employer Health Benefits 2011 Annual Survey 1 (2011), available at http://ehbs.kff.org/pdf/2011/8225.pdf ("[s]ince 2001, average premiums for family coverage have increased 113%").

Any of these alternatives would be permissible under ERISA, which, as noted above, does not force employers to provide plans or any particular benefits. See supra at 5-6. Yet they are not necessarily desirable outcomes, which is precisely why so many employers and participants agree to plan terms that require beneficiaries to reimburse plans for up-front medical payments when they subsequently obtain recovery for their medical costs. See infra at 20-21. Equitable relief that enforces that agreement is, virtually by definition, "appropriate" equitable relief.

III. ENFORCING PLAN REIMBURSEMENT PROVISIONS DOES NOT PRODUCE UNJUST RESULTS

A. Reimbursement Provisions Reflect A Rational And Fair Contractual Bargain

When an employer sponsors an employee benefits plan, it is agreeing to provide only those benefits that are specified in the text of the governing documents, and only on such terms as those documents provide. Here, the governing documents could hardly be more clear that the plan would be entitled to reimbursement to the full extent of any third-party recovery. As the Plan's Summary Plan Description explained, "[t]he purpose of the Plan is to provide coverage for qualified expenses that are not covered by a third party." Pet. App. 4a (emphasis added). Thus, participants are "required to reimburse the Plan for amounts paid for claims out of any monies recovered from a third party." Id. at 4a-5a (emphasis added).

The agreement was, in short, unambiguous. McCutchen thus was necessarily aware that when

he accepted the plan's immediate payment of his medical bills, he would be required to reimburse the plan fully out of any recovery he received from a third party. See O'Hara, 604 F.3d at 1238. agreement was an entirely rational one for plan participants to enter into. See Shank, 500 F.3d at 839; Schwade, 837 F. Supp. at 1279. Participants (and their medical providers) receive certainty that the plan will pay their medical bills immediately, avoiding the difficult—and sometimes practically impossible-task of having to negotiate provider fees and arrange payment out-of-pocket. In exchange for that assurance of payment, participants promise to reimburse the plan for those payments if they receive settlements or judgments that cover their medical bills. There is nothing unjust about that exchange. Just the opposite: the promise of reimbursement is eminently reasonable consideration for the assurance of up-front payment. See Varco, 338 F.3d at 692 ("plan participants have traded the possibility of having the Plan participate in attorney's fees for the guarantee that medical bills will be paid immediately").

Moreover, as already noted, it is a bargain all participants accept when they join the plan. To treat one participant differently on grounds of equity is not only inequitable to other participants, it imposes concrete injury on them by depleting overall plan assets, causing increased premiums and other costs and diminished benefits. As this Court recently noted in a different context, it may be difficult for courts, which see only one case at a time, to appreciate the consequences that one equitable decision will have on other beneficiaries. See Riegel v. Medtronic, Inc., 552 U.S. 312, 325 (2008) ("A jury . . . sees only

the cost of a more dangerous design, and is not concerned with its benefits; the patients who reaped those benefits are not represented in court.").

B. This Court Should Not Recognize A General Equitable Exception To Enforcement Of Reimbursement Provisions Based On The Anomalous Facts Of This Case

This case exemplifies the risk of making individualized decisions about enforcement of plan terms under the guise of equity. The court of appeals thought that adhering to the plan was too harsh because McCutchen's tort recovery, net of claimed attorneys' fees, was allegedly less than the payments already made on his behalf. According to the court of appeals, then, equity requires that McCutchen satisfy his contractual obligation to his attorneys before he satisfies his contractual obligation to his plan.

If equity has anything at all to say about the priority of his contractual obligations, it appears to favor enforcement of a plan reimbursement obligation first, because it is an "equitable lien by agreement," as petitioner explains. Pet'r Br. 29-41. But either way, the particular result in this case is unquestionably anomalous. McCutchen's alleged net loss results from a relatively small difference between the plan's payment (\$66,866) and the third-party recovery (\$110,000), as well as the high 40% lawyers' contingency fee, which allegedly reduced his recovery so severely (down to \$66,000) as to leave him \$866 short on his reimbursement obligation. Petitioner's brief indicates that the record does not actually es-

tablish that he was left short (Pet'r Br. 10 n.3), but if he was, his case is atypical. More commonly the third-party recovery is substantially higher than the plan's payment, leaving the participant with a net recovery even after reimbursing the plan and paying his attorneys. In Rose, for example, the Ninth Circuit applied McCutchen to override the plan terms and authorized the district court to deny full reimbursement of approximately \$32,000, even though the beneficiary obtained a third-party recovery of \$376,906.84. 683 F.3d at 1116. In Moore, the beneficiary sought to avoid fully reimbursing the plan for \$200,000 in medical costs after she recovered \$1.3 million in a personal-injury settlement. 461 F.3d at 4; see also O'Hara, 604 F.3d at 1234 (\$262,611 benefit plan payment versus \$1.2 million third-party recovery); K-VA-T Food Stores, Inc. v. Hutchins, 2012 U.S. Dist. LEXIS 26575, at *6-7 (W.D. Va. Mar. 1, 2012) (noting that "allowing full recovery by the plan" will not put the participant "in a worse position than if he had not pursued a third-party recovery at all"").

Even if one thinks equity must preclude full reimbursement—despite an express contractual obligation—when it would result in a net loss given the beneficiary's other contractual obligations, there is surely no basis for allowing any equitable defense when the beneficiary's net recovery does permit full reimbursement, or for allowing any equitable defense that would preclude reimbursement up to the full amount of the net recovery.³ Equitable relief

³ To be clear, amici believe ERISA requires adherence to the plan terms in all cases (unless they violate some substantive provision of ERISA or involve fraud or mutual mistake).

under § 502(a)(3) must be "appropriate," and relief that violates the parties' contractually-defined expectations, while inviting further asset-depleting litigation, is not "appropriate" in any sense of the term.

CONCLUSION

For the foregoing reasons, and for the reasons stated by the petitioner, the judgment below should be reversed.

But if equity compels some exception where full reimbursement pursuant to a plan term would result in a net loss, the exception should be categorically limited to that situation, given ERISA's emphasis on following plan terms and establishing clear, uniform rules. That is, if there must be an equitable exception for a case like this, it should simply provide that a beneficiary cannot be compelled to reimburse the plan beyond the extent of his net recovery, but that the beneficiary otherwise must adhere to his plan reimbursement obligations. That categorical exception here would relieve McCutchen of the obligation to pay the \$866 representing his net loss (assuming there is actually such a loss), but would require reimbursement of the remaining \$66,000 paid on his behalf.

Respectfully submitted,

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AMICUS CURIAE BRIEF

OCT 2 5 2012

No. 11-1285

IN THE

Supreme Court of the United States

U.S. AIRWAYS, INC., IN ITS CAPACITY AS FIDUCIARY AND PLAN ADMINISTRATOR OF THE U.S. AIRWAYS, INC., EMPLOYEE BENEFITS PLAN,

Petitioner.

v.

JAMES MCCUTCHEN AND ROSEN, LOUIK & PERRY, P.C.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF AMICUS CURIAE CONSUMER WATCHDOG IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

Amicus Consumer Watchdog addresses only this question:

Whether a court responding to an equitable claim under Section 502(a)(3) of ERISA should apply the common fund doctrine, which requires that all parties benefiting from a settlement fund share in the costs of its creation.

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INTEREST OF AMICUS¹

Consumer Watchdog is a nonprofit, nonpartisan consumer advocacy organization with offices in California and Washington, D.C., specializing in the application of state and federal consumer protection laws, including enforcement of the landmark California insurance reform measure, Proposition 103, and other insurance and health care statutes and regulations. Founded in 1985, Consumer Watchdog advocates for the rights of consumers and seeks to hold corporations accountable in the legislature and the courts.

For over two decades, Consumer Watchdog has studied and reported on the application of ERISA to health care and insurance laws, and in particular ERISA's impact on consumers. As explained below, Consumer Watchdog urges that ERISA be interpreted as Congress desired: to preserve traditional equitable principles, such as the common fund doctrine, that encourage claimants and their attorneys to pursue meritorious claims and ensure that injured consumers obtain the recoveries to which they are entitled.

¹ This brief is filed under the parties' blanket consents filed with the Court. No person other than amicus Consumer Watchdog or its counsel authored this brief or provided financial support for it.

STATEMENT

On January 24, 2007, respondent James McCutchen was involved in a three-car accident caused by a negligent driver. He sustained serious physical injuries, including a concussion and loss of consciousness, a fracture and dislocation of his hip, extensive lacerations, and neck and back injuries. He underwent emergency surgery and ultimately received a total hip replacement. He continues to suffer from severe chronic back pain that has rendered him disabled. Jt. App. 60-61. At the time of the accident, McCutchen was a participant in petitioner U.S. Airways' self-funded health benefit plan. Jt. App. 4. U.S. Airways paid for McCutchen's medical expenses from the accident, which totaled \$66,865.82. Jt. App. 5.

After the accident, McCutchen retained a law firm, respondent Rosen, Louik & Perry, P.C., to pursue claims relating to the accident. Jt. App. 6. McCutchen and his attorneys entered into a contingency fee agreement. Pet. App. 3a. Under that agreement, the lawyers agreed to cover all expenses related to McCutchen's claims, and McCutchen agreed to pay his lawyers 40% of any recovery they obtained, plus expenses. Pet. App. 3a.

Because three other people were seriously injured or killed in the accident and the negligent driver had limited insurance coverage, McCutchen received only \$10,000 in settlement with the negligent driver. Pet. App. 3a, 20a. With the help of his attorneys, McCutchen also obtained \$100,000 from his underinsured motorist coverage. Jt. App. 11, 12. After de-

ducting attorney's fees and expenses, McCutchen was left with less than \$66,000. Pet. App. 3a.

U.S. Airways waited until these settlements were completed and then sued McCutchen and his attorneys in federal district court under ERISA Section 502(a)(3), demanding full reimbursement of the medical bills it paid for McCutchen. Pet. App. 4a. It relied on a provision in its ERISA plan contract that purports to require participants to "reimburse the Plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, a beneficiary's own insurance company as the result of a judgment, award, settlement, or otherwise." Jt. App. 7. The district court granted summary judgment to U.S. Airways, requiring McCutchen and his attorneys to pay \$66,865.82 to U.S. Airways, \$865.82 more than McCutchen's total recovery after attorney's fees. Pet. App. 18a-35a.

The Third Circuit reversed. Noting that ERISA Section 502(a)(3) authorizes only "appropriate equitable relief," the court concluded that allowing U.S. Airways full reimbursement would be inequitable because that reimbursement would "exceed[] the net amount of McCutchen's third-party recovery." Pet. App. 16a. The Third Circuit remanded to the district court to apply equitable principles, including the common fund doctrine, to determine the appropriate distribution of the settlement fund. Pet. App. 17a.

SUMMARY OF ARGUMENT

The common fund doctrine is a well-established rule of equity, designed to prevent the unjust enrichment of those who passively accept the benefits of settlements and judgments procured by others. Courts have consistently applied the doctrine in insurance subrogation and reimbursement cases like this one to prevent insurers from accepting proceeds of a settlement fund without sharing in the costs of its creation.

- U.S. Airways argues that the common fund doctrine does not apply in this case because McCutchen waived his right to reimbursement for attorney's fees when he agreed to the terms of his ERISA plan. But U.S. Airways' argument ignores basic equitable principles and the nature of the common fund doctrine.
- U.S. Airways' claim, as required by Section 502(a)(3), is one for equitable, not legal, relief. As such, its claim is subject to the maxim "he who seeks equity must do equity." A party who asks the court for equitable relief cannot hide behind the terms of a contract, unenforceable at law, to avoid the application of established equitable principles like the common fund doctrine.

Moreover, even if McCutchen could waive his own rights under the common fund doctrine, he cannot waive the rights of his attorneys, respondent Rosen, Louik & Perry. The common fund doctrine grants a successful claimant and his attorney independent rights to recover reasonable attorney's fees from passive beneficiaries. Rosen, Louik & Perry was not par-

ty to the ERISA contract and has not waived its rights to recovery.

The "unfortunate consequences" U.S. Airways claims might result if courts apply equitable principles are either red herrings or do not apply to the common fund doctrine. Evidence suggests that a reduction in reimbursement and subrogation recoveries would have, at most, a tiny (<1%) effect on the premiums paid by ERISA plan participants.

Eliminating the common fund doctrine would, on the other hand, have serious negative consequences for plan participants. By deterring plan members' legitimate claims, it would reduce recovery for plan participants generally, and place a particularly high financial burden on participants who are most in need—individuals, like McCutchen, who have sustained serious injuries. Many injured plan members with valid claims against negligent third parties would be unable to enforce them at all. ERISA was designed to protect the rights of plan participants, not undermine them.

ARGUMENT

 The common fund doctrine is a well-settled rule of equity that applies to this type of case.

The common fund doctrine is a long-standing rule of equity that has consistently been applied by both federal and state courts since 1881. See, e.g., Internal Imp. Fund Trustees v. Greenough, 105 U.S. 527, 537 (1881) (establishing the doctrine); Chambers v. NASCO, Inc., 501 U.S. 32, 45 (1991) (affirming the

equitable power of federal courts to award attorney's fees for the creation of a common fund); Appeal of Harris, 186 A. 92, 95 (Pa. 1936). The doctrine requires all beneficiaries of a fund to share proportionately in the costs of its creation. 7A C.J.S. Attorney & Client § 416 (2012).

All of the required elements of the common fund doctrine are present in this case, and U.S. Airways should be required under that doctrine to pay its proportionate share of McCutchen's attorney's fees.

A. The common fund doctrine seeks to prevent the unjust enrichment of free riders, and U.S. Airways is a quintessential free rider.

The common fund doctrine was designed to prevent a particular form of unjust enrichment, sometimes referred to as "free-riding." See, e.g., duPont v. Shackelford, 369 S.E.2d 673, 677 (Va. 1988) ("In short, the common fund doctrine is aimed at preventing 'free rides."). Free-riding occurs when an attorney creates a fund by performing legal services and someone other than the attorney's client benefits from the fund without contributing to its creation. 1 Dan B. Dobbs, Law of Remedies: Damages-Equity-Restitution § 3.10(2) (2d ed. 1993). The common fund doctrine is employed in these situations to spread the cost of dispute resolution equitably among all fund beneficiaries. It ensures that "the active beneficiary is not forced to bear the burden alone and the 'stranger' (i.e., passive) beneficiaries do not receive their benefits at no cost to themselves." Means v. Montana Power Co., 625 P.2d 32, 37 (Mont. 1981).

In this Court's first case to recognize the doctrine, the plaintiff, a holder of bonds in the Florida Railroad Company, sued to protect the fund that secured the bonds, which was being wasted by unscrupulous trustees. *Greenough*, 105 U.S. at 528-29. He was successful and managed to save the fund to the benefit of all bondholders. *Id.* at 529. Those bondholders were able to collect their shares of the fund as the result of the plaintiff's litigation. *Id.*

Recognizing that it would be unjust to place the entire burden of the litigation on the one bondholder willing to take the initiative and save the fund while allowing other bondholders to free ride, the Court adopted a new rule of equity. See id. at 532; see also, e.g., Gibbs v. Blackwelder, 346 F.2d 943, 945 (4th Cir. 1965) (holding that an equity court has full power to award counsel fees to the "trail blazer" so that "one who led in hewing the path to victory is not left saddled with extensive attorney fees" which were not incurred "by his more timid fellows who held back until the fruits of the pioneer's success were laid before them"). Drawing on examples from the English common law of trusts, Greenough held that when a plaintiff "recovers a fund for the general benefit," his costs "are to be paid either out of the fund or pro rata by all the creditors who partake of the benefit of the suit." 105 U.S. at 533.

ERISA plan fiduciaries making reimbursement claims, like U.S. Airways here, are quintessential free riders. Under its ERISA plan contract, U.S. Airways had a right to join McCutchen's settlement negotiations or bring a suit directly against the negli-

gent driver who caused McCutchen's injuries. See Jt. App. 20 (U.S. Airways Health Benefit Plan for Employers) (granting U.S. Airways full subrogation rights); 46A C.J.S. Insurance § 1993 (2012) (describing the rights available to an insurer in subrogation). U.S. Airways exercised none of these rights. Instead, it sat back and waited, allowing McCutchen to assert claims against the negligent driver and her car insurance company. Once McCutchen and his attorneys successfully negotiated a settlement, U.S. Airways swooped in and demanded to be fully reimbursed out of the settlement fund.

If U.S. Airways is allowed to collect from the settlement fund without paying its proportionate share of the cost of creating the fund, it will be unjustly enriched. This is exactly the situation the common fund doctrine was designed to remedy.

B. This case meets all of the requirements of the common fund doctrine.

The common fund doctrine requires the establishment of three elements: (1) a party must successfully resolve a dispute, resulting in a fund over which the court has jurisdiction and from which fees can be awarded; (2) the creation, preservation, or enhancement of the fund must be a proximate result of the efforts of counsel for that party; and (3) an outside party must demand or receive benefits of the fund, without contributing to its creation. See United Services Auto. Ass'n v. Hills, 109 N.W.2d 174, 177 (Neb. 1961); see generally Johnny Parker, The Common Fund Doctrine: Coming of Age in the Law of Insurance Subrogation, 31 Ind. L. Rev. 313, 322-23 (1998).

This case meets all of the requirements. First, McCutchen's settlement satisfies the requirement of a "successful termination" that resulted in a fund from which fees could be awarded. See, e.g., Hills, 109 N.W.2d at 178. Second, the creation of a fund—in this case, the settlement fund—was the direct result of McCutchen's attorneys' efforts. See Pet. App. 20a. Finally, U.S. Airways has demanded \$66,866 from that settlement fund without participating in its creation. See Pet. App. 20a.

Courts have consistently held that application of the common fund rule is appropriate in cases where, as here, an insurer is claiming reimbursement from a fund created by an insured. John P. Dawson, Lawvers and Involuntary Clients: Attorney Fees from Funds, 87 Harv. L. Rev. 1597, 1622 (1974) (citing relevant cases from a variety of jurisdictions); Parker, supra, 31 Ind. L. Rev. at 334 (same). But insurers are not helplessly bound to pay the fees negotiated by their plan participants. Only passive beneficiaries of a fund are subject to the common fund doctrine. An insurer that "actively participates," either by participating in settlement negotiations, intervening in a legal action, or bringing an independent "subrogated" claim on its own behalf, has no obligation to contribute to the insured's attorney's fees. See Dawson, supra, 87 Harv. L. Rev. at 1647 (noting that a beneficiary who hires his own attorney and takes part in litigation "becomes a contributor to the final result, so that two essential bases of the Greenough doctrine are eliminated").

It is only the passive free rider, who contributes nothing to the fund's creation and then demands a share of it, who must pay a proportionate share of the claimant's legal expenses. U.S. Airways is just such a passive free rider. Having contributed nothing to McCutchen's efforts, U.S. Airways cannot now claim the benefits of the fund without sharing in the costs of its creation.

II. An ERISA plan's contractual language cannot override the application of the common fund rule.

U.S. Airways has argued that the language in McCutchen's ERISA plan effectively bars the application of equitable principles that would otherwise be available to McCutchen, including the common fund doctrine. This argument fails for two reasons.

First, because U.S. Airways is bringing an equitable claim—the only type of claim available under ERISA Section 502(a)(3)—not a legal claim, it must abide by the equitable maxim "he who seeks equity must do equity" and submit its claim to all clearly-defined equitable principles, including the common fund doctrine. See Manufacturers' Fin. Co. v. McKey, 294 U.S. 442, 449 (1935) (explaining the maxim).

Second, even if McCutchen could have contractually waived his own rights under the common fund doctrine, he had no authority to waive the rights of his attorneys under that doctrine. McCutchen's attorneys have an independently enforceable right to reimbursement for their services that cannot be waived by a contract to which they are not parties.

A. U.S. Airways cannot bring its "purely equitable claim" against McCutchen without affording him his "correlative equitable rights."

The equitable powers of a court cannot be limited by contract. When one party invokes the court's equitable powers by requesting equitable relief, she necessarily subjects her claim to all the equitable principles that would usually apply. As this Court explained in McKey, purely equitable rights "shall not be enforced in favor of one who affirmatively seeks their enforcement except upon condition that he consent to accord to the other his correlative equitable rights." 294 U.S. at 449. Because U.S. Airways' claim is purely equitable—and, again, only equitable are permissible under ERISA Section 502(a)(3)—it must afford McCutchen and his attorneys their correlative equitable rights, which in this case includes the common fund doctrine.

1. U.S. Airways' claim, like all claims arising under Section 502(a)(3), is "purely equitable."

In the days of the divided bench, not all claims raised in a court of equity were equitable in nature. "Purely equitable" claims were distinguishable from "essentially legal" claims that nonetheless had to be raised in a court of equity. See McKey, 294 U.S. at 448-49 (discussing the distinction). Nearly all claims arising from a breach of trust, for example, had to be raised in a court of equity, whether they were equitable or legal in nature. Mertens v. Hewitt Associates,

508 U.S. 248, 256 (1993) (citing Lessee of Smith v. McCann, 16 L.Ed. 714 (1861)).

A party who was obliged to go into a court of equity to enforce an "essentially legal" contractual right could be secure that the terms of the contract would not be changed absent fraud, accident, or mistake. *McKey*, 294 U.S. at 448-49. "Legal rights," this Court has explained, "are as safe in chancery as they are in a court of law." *Id.* at 449 (internal quotations omitted).

On the other hand, a party who seeks purely equitable relief cannot avoid the application of established equitable principles, by contract or otherwise. See Parker, supra, 31 Ind. L. Rev. at 338 n.115 ("[J]udicial discretion to respond to equity cannot be bargained away. Thus, the principle of equity is subject to judicial review even where the parties have otherwise entered into an agreement."); Fosdick v. Schall, 99 U.S. 235, 253 (1878) (mortgagee seeking equitable remedy of receivership, though entitled under mortgage to a lien on all receipts, cannot complain when court allows receiver to apply receipts towards current debts). By asking the court to use its equitable powers to grant relief, a party consents to "accord to the other his correlative equitable rights." McKey, 294 U.S. at 449.2

² Cf. Daniels v. Johnson, 351 S.W.2d 853, 855 (Ark. 1961) (plaintiff seeking equitable remedy cannot invoke statute of limitations to avoid defendant's correlative lien); 2 S. Symons, Pomeroy's Equity Jurisprudence § 385, at 59 (5th ed. 1941) (noting that a party seeking equitable relief cannot invoke the

- U.S. Airways' claim against McCutchen, like all claims arising under Section 502(a)(3), is equitable and not legal in nature. Section 502(a)(3) authorizes a fiduciary to bring a civil action to obtain "appropriate equitable relief." 29 U.S.C. § 1132(a)(3). As this Court explained in *Mertens*, relief under Section 502(a)(3) is limited to "those categories of relief that were typically available in equity" and does not include legal remedies that could have been granted by a common-law equity court. 508 U.S. at 256 (emphasis in original).
- U.S. Airways has framed its claim as one for an "equitable lien by agreement," rather than one for breach of contract. An equitable lien is, as its name indicates, an equitable, not a legal, remedy. See 1 G. Palmer, Law of Restitution § 1.4, at 17; § 3.7, at 262 (1978). Fashioning its claim in this way enables U.S. Airways to shoehorn a contract claim into the equitable demands of Section 502(a)(3). But it also places the claim squarely within the rule that a party who seeks equity must do equity. By bringing an equitable, rather than legal, claim, U.S. Airways consented to accord McCutchen and his lawyers their correlative equitable rights.
- U.S. Airways has argued that an equitable lien by agreement must always be enforced strictly according to its terms. The sources cited in its brief (at 33-36), however, do not support such a broad assertion. To be sure, a court of equity will, in appropriate cir-

statute of limitations to avoid a defendant's correlative rights).

cumstances, "seek[] to effectuate the intention of parties to contracts, and will, to that end, aid their defective execution." Bernard v. Lea, 210 F. 583, 595 (4th Cir. 1913). But no court of equity will enforce an agreement that would result in unjust enrichment or any other inequity. See 27A Am. Jur. 2d Equity § 84 (2012) ("A court of equity is never required to render, or justified in rendering, an inequitable decision or decree.").

Not a single case or treatise cited by U.S. Airways demonstrates that the terms of a contract, unenforceable at law, as the contract is here, can nonetheless be enforced in equity without the application of established equitable principles. U.S. Airways' claim, like all equitable claims, is subject to the correlative equitable rights of McCutchen and his attorneys.

McCutchen's right to reimbursement under the common fund doctrine is a correlative equitable right.

As explained above, when a plaintiff raises an equitable claim, he must accord the defendant his correlative equitable rights. Those rights include all rights "growing out of or necessarily involved in the subject matter of the controversy." 2 S. Symons, Pomeroy's Equity Jurisprudence § 385, at 52 (5th ed. 1941); see also 30A C.J.S. Equity § 101 (2012) ("[A]ny person seeking the aid of equity . . . will be compelled to accord, to the other party all the equitable rights to which the other is entitled in respect of the subject matter involved.") (emphasis added).

For example, after rescinding a contract for the purchase of land, a court will order repayment by the seller of the purchase price, but it will also require the buyer seeking the equitable rescission to pay an amount equal to the fair rental value of the property during the time of possession. See Cardiac Thoracic and Vascular Surgery, P.A. Profit Sharing Trust v. Bond, 840 S.W.2d 188, 193-94 (Ark. 1992). The seller's claim for fair rental value arises directly from the buyer's claim for rescission. See id.

McCutchen's claim for partial recoupment of his attorney's fees likewise arises directly from U.S. Airways' claim for reimbursement. In the rescission example, the buyer would be unjustly enriched if she were allowed to rescind the contract without compensating the seller for the time he occupied the property. U.S. Airways would likewise be unjustly enriched if it were allowed to share in the benefits of the fund without sharing in the cost of the fund's creation.

In sum, the unjust enrichment that the common fund doctrine was designed to remedy arises as a direct result of U.S. Airways' equitable claim and is inseparable from it. McCutchen's right to reimbursement under that doctrine is thus a correlative equitable right that must be honored under ERISA Section 502(a)(3).

B. Even if McCutchen could contractually waive his own rights under the common fund doctrine, he cannot waive his attorneys' independent right to recover fees under that doctrine.

McCutchen's attorneys, respondent Rosen, Louik & Perry, have a right to recover their reasonable attorney's fees that is independent of McCutchen's right to reimbursement under the common fund doctrine. Even if McCutchen could contractually waive his own rights under the common fund doctrine—and for the reasons explained above, he has not—he lacked authority to waive his attorneys' rights, and his attorneys, as non-parties to the contract, cannot be bound by the contract's terms.

The attorneys' right to their reasonable fees is secured by a first-priority lien on the fund, and their interest must be satisfied before any distribution can be made. Thus, any distribution from the fund to U.S. Airways must be reduced by U.S. Airways' pro rata share of Rosen, Louik & Perry's reasonable attorney's fees.

 McCutchen's attorneys have an independently enforceable right to recover their reasonable attorney's fees from each party that benefits from the fund, including U.S. Airways.

Courts have long recognized that attorneys have a right to recover reasonable fees from beneficiaries of a common fund. See, e.g., Cent. R.R. & Banking Co. v. Pettus, 113 U.S. 116, 124-25 (1885) ("[W]hen an allowance to the complainant is proper on account of solicitors' fees, it may be made directly to the solicitors themselves, without any application by their immediate client."). This right is independent of the client's right to recover his own fees. Dawson, supra, 87 Harv. L. Rev. at 1605-06 (explaining that either a client or lawyer can secure a charge on a common fund). Thus, an attorney may have a claim under the

common fund doctrine even if her client does not. See Washington Gas Light Co. v. Baker, 195 F.2d 29, 33-34 (D.C. Cir. 1951) (attorney can bring a common fund claim even though he agreed to serve his client gratuitously); Wallace v. Fiske, 80 F.2d 897, 909-11 (8th Cir. 1935) (denial of client's petition for contribution does not bar the lawyer's separate claim for a fee, chargeable to the fund).

McCutchen's attorneys, who are party to this action, have a right under the common fund doctrine, independent of McCutchen's own right, to require any beneficiary of the fund, including U.S. Airways, to pay its proportionate share of reasonable attorney's fees. See, e.g., Boeing Co. v. Van Gemert, 444 U.S. 472, 476, 481 (1980) (upholding district court order requiring each beneficiary of a common fund to "carry its proportionate share of the total amount allowed for fees, expenses, and disbursements").

U.S. Airways has argued that an equitable lien by agreement "cannot be invoked to create a right contrary to the agreement of the parties," and thus must be enforced in accordance with the terms of the contract. Pet. Br. 4 (citation omitted). Even if that is true, it does not apply to the rights of McCutchen's attorneys. They are not parties to any contract with U.S. Airways and cannot be bound in equity or at law. Their right to recover is enforceable regardless of any waiver by McCutchen of his own right.³

³ The only court to address the attorney's independent right in the ERISA reimbursement context held that the right could not be voided by ERISA plan terms. See Bishop v. Burgard, 764

The common fund doctrine grants the attorney who creates a fund a firstpriority lien, which must be satisfied before any funds can be distributed.

The right of McCutchen's counsel to insist that all fund beneficiaries pay a proportionate share of their attorney's fees is secured by a first-priority lien on the settlement fund. See Dawson, supra, at 1606-07 ("[T]he claim for legal services is a first charge on the fund and must be satisfied before any distribution occurs."). That lien is superior to all other liens that may attach, including U.S. Airways' claimed equitable lien by agreement. See, e.g., Winslow v. Harold G. Ferguson Corp., 153 P.2d 714, 719 (Cal. 1944) (attorney's lien prevails over not only the claims of other creditors but also the lien of the federal government for income taxes); United States v. Hubbell, 323 F.2d 197, 200-01 (5th Cir.1963) (same); Appeal of Harris, 186 A. at 97 (attorney's lien is superior to pre-existing mortgage).

This outcome is consistent with the first-in-time, first-in-right rule for common-law liens. Common-law liens are granted priority based on the time of attachment. Meyer v. United States, 375 U.S. 233,

N.E.2d 24, 30-32 (Ill. 2002). The issue was also raised in the Seventh Circuit, but the plan participant's attorney was not a party to the suit. The court declined to address the issue, suggesting that the plan participant did not have standing to enforce the attorney's right. See Admin. Comm. of Wal-Mart Stores, Inc. Associates' Health & Welfare Plan v. Varco, 338 F.3d 680, 690-91 (7th Cir. 2003). Because Rosen, Louik & Perry is a party here, standing is not an issue.

236 (1963). When the object of a lien by agreement is a fund not yet in existence at the time the contract is signed, the lien does not attach until the fund is created. See Sereboff v. Mid Atl. Med. Services, Inc., 547 U.S. 356, 363-64 (2006).

Although U.S. Airways' contract with McCutchen preceded any action by McCutchen's attorneys, the attorneys' lien and U.S. Airways' lien both attached at the moment the settlement fund was created. See Sereboff, 547 U.S. at 364 (insurance reimbursement lien attaches at moment fund is created); Metro. Life Ins. Co. v. Poliakoff, 198 A. 852, 854 (N.J. Ch. 1938) (attorney's lien "fastens to the fund as soon as it takes form"); Coughlin v. New York C. & H. R.R. Co., 27 Am. Rep. 75 (N.Y. 1877) (agreement to assign a portion of recovery "would attach itself to the judgment when recovered"). And, the attorney's lien historically has been given preference because of the attorney's indispensible role in creating the fund. See Winslow, 153 P.2d at 719-20 ("[S]uch counsel fees are customarily made senior to other claims against the fund" because the attorneys "brought into the protective custody of the court the trust assets."); see also Appeal of Harris, 186 A. 92 at 97 (although rights assigned by client would generally be subject to mortgage, the attorney is "not a mere assignee" of the fund because "his efforts contributed to its creation").

As noted, because the attorney's lien is a first-priority lien, it must be satisfied before any distribution can be made. See Dawson, supra, 87 Harv. L. Rev. at 1606-07. Any distribution to U.S. Airways thus must be reduced by its pro rata share of Rosen,

Louik & Perry's reasonable attorney's fees. See, e.g., Hills, 109 N.W.2d at 177-78 (reducing insurance company's recovery in subrogation by its pro rata share of attorney's fees).

III. Permitting an ERISA plan to eliminate the common fund rule would have perverse consequences.

U.S. Airways has suggested that anything short of a hard-and-fast, contract-always-controls rule would have "unfortunate consequences," including increased premiums for plan participants and unnecessary litigation. Pet. Br. 16. Evidence indicates that applying equitable principles would have no such impact. Eliminating the common fund doctrine, on the other hand, would have a very real negative impact on plan participants. By creating a powerful disincentive for both participants and their attorneys to assert legitimate claims, elimination of the rule would reduce recoveries for participants in general, and for injured participants in particular. Those effects would be at odds with ERISA's principal purpose of protecting plan participants.

A. U.S. Airways' argument that the application of equitable principles would result in increased premium rates and protracted and costly litigation is not supported by evidence.

U.S. Airways' claim that the reduction of subrogation and reimbursement recoveries would increase costs for plan participants and ultimately threaten the financial viability of plans is unfounded. Numerous scholars have concluded that insurance plans consistently fail to factor subrogation and reimbursement recoveries into rate calculations.⁴

Even if insurance companies were to increase participants' premiums because of a reduction in reimbursement recoveries, the effect would be very small. See E. Farish Percy, Applying the Common Fund Doctrine to an ERISA-Governed Employee Benefit Plan's Claim for Subrogation or Reimbursement, 61 Fla. L. Rev. 55, 96-97 (2009). In 2000, the largest subrogation services provider reported that it recovered an average of \$4.80 in subrogation and reimbursement per covered person per year. See id. at 97. Even if that entire recovery were eliminated—and only a fraction of it would be affected by the common fund doctrine—ERISA plans could make up for the

⁴ See, e.g., John F. Dobbyn, Insurance Law in a Nutshell 384 (4th ed. 2003) (arguing that subrogation has not reduced insurance rates because "[i]nsurers consistently fail to introduce the factor of such recoveries into rate-determining formulae, but rather apply such recoveries to increasing dividends to shareholders"); Roger M. Baron, Public Policy Considerations Warranting Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom, 55 Mercer L. Rev. 595, 627-31 (2004) (explaining that insurers do not consider subrogation when setting insurance rates); Johnny C. Parker, The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation, 70 Mo. L. Rev. 723, 737 (2005) ("[S]ubrogation has not led to lower premium costs for the insured." (citing various sources)); Brendan S. Maher & Radha A. Pathak, Understanding and Problematizing Contractual Tort Subrogation, 40 Loy. U. Chi. L.J. 49, 58 n.31 (2008) ("[I]t is likely that insurers will not offer lower subrogation adjusted rates even though they will grant themselves a subrogation right").

deficit by charging each plan participant an extra \$4.80 per year in premiums.

The statistics presented by Petitioner's amicus, Central States, Southeast and Southwest Areas Health and Welfare Fund, paint the same picture. Central States reported its average annual reimbursement recoveries at \$5.7 million, only one half of one percent of the approximately \$1 billion it pays in benefits each year. Thus, even complete elimination of Central States' reimbursement rights—and, again, only a fraction would be affected by the common fund doctrine—would increase the plan's costs by less than 1%.

Nor would the common fund rule result in unnecessary or protracted litigation. The only litigable issue U.S. Airways has pointed to in the common fund context is the reasonableness of attorney's fees. But courts in insurance subrogation cases generally presume the reasonableness of the client's contingency fee. See, e.g., Klacik v. Kovacs, 268 A.2d 305, 308 (N.J. App. Div. 1970); Tenn. Farmers Mut. Ins. Co. v. Pritchett, 391 S.W.2d 671, 675 (Tenn. Ct. App. 1964); State Farm Mut. Auto. Ins. Co. v. Elkins, 451 S.W.2d

⁵ See Central States Br. 3 (stating average reimbursement recoveries); Central States, Southeast and Southwest Areas Health and Welfare Fund, Comments on the Proposed and Interim Rules Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act 2 (Sept. 24, 2010), available at http://www.dol.gov/ebsa/pdf/1210-AB45-0087.pdf (reporting annual benefit payments).

528, 531-32 (Tex. Ct. Civ. App. 1970). As Judge Posner has explained, a fee negotiated at arms length—as contingency fees are in these cases—is the most appropriate measure of reasonableness. In re Continental, Illinois Sec. Litig., 962 F.2d 566, 572 (7th Cir. 1992); see also American Law Institute, Contrasting Approaches in Awarding Attorneys' Fees, C852 ALI-ABA 257, 264 (1993) ("[T]he attorney should receive a fee comparable to that which the beneficiaries would have to pay in the marketplace for the legal services.") We know of no evidence showing much, if any, litigation over the reasonableness of personal-injury contingency fees, and U.S. Airways points to none.

In the rare circumstance where parties find it necessary to litigate the issue, it could be resolved in a simple hearing, where evidence is presented on the market rate for lawyers in the area, the amount of time spent, and the expenses incurred in the course of litigation. There would be no need to hold a full-blown trial or conduct extensive factual investigation.⁶

⁶ Amicus Blue Cross Blue Shield Association suggests that there may be litigation over whether or not the insurance plan actually benefited from the efforts of beneficiaries' attorneys because the insurance plan may have been able to recover directly from the tortfeasor at a lower cost. BCBSA Br. 8. This argument is more than a little ironic coming from the friend of a party who could have brought its own litigation but instead sat by and let the insured and its lawyers do all the work. In any event, no court has ever required that a third party benefit in this broad, existential sense. When a party demands money

Experience also demonstrates that apportionment of attorney's fees does not result in excessive litigation. As the United States points out (U.S. Br. 28-30), reimbursement obligations are limited by attorney's fees in other circumstances. For example, under both Medicare regulations and the Federal Employees' Compensation Act, participants' reimbursement obligations are reduced by the costs of the suit, including a reasonable attorney's fee. See 5 U.S.C. § 8132. The Longshore and Harbor Workers' Compensation Act prohibits reimbursement payments to employers from exceeding the employee's net amount recovered after reasonable attorney's fees and expenses are deducted. See 33 U.S.C. § 933(f). U.S. Airways has not pointed to any evidence of extensive litigation over reasonable attorney's fees in these situations.

In sum, the supposed harms to plan participants from applying the common fund doctrine are at best insubstantial and possibly non-existent. And, as we now explain, the harms of eliminating the rule would be substantial.

from a fund, it is seeking a benefit. See supra at 8-9 (discussing elements of common fund doctrine); see also Dawson, supra, 87 Harv. L. Rev. at 1627 (When the litigation brought against a tortfeasor has succeeded, "the question will be whether it has conferred a benefit on a fund.") (emphasis added).

- B. Eliminating the common fund doctrine would discourage injured plan members and their counsel from bringing meritorious claims.
 - Expansive insurance reimbursement rights generally discourage legitimate claims by injured plan participants.

When deciding whether to assert a claim against a tortfeasor, plan participants and their attorneys must weigh the potential for recovery from a successful settlement or trial against the associated expenses and risk.

Attorneys are sensitive to this balancing of risk and reward. The vast majority of accident claims are brought by attorneys acting under a contingency fee agreement. James D. Dana & Kathryn E. Spier, Expertise and Contingent Fees: The Role of Asymmetric Information in Attorney Compensation, 8 J. L. Econ. & Org. 349, 349 (1993) (96 percent of plaintiffs paid their attorneys on a contingency fee basis). Under those agreements, attorneys cover all of the costs of asserting the claim and dedicate their own time without charging the client. Id. In exchange, they are entitled to a percentage of the client's recovery. Id. An attorney deciding whether to take on a contingency-fee client has to consider not only the strength of the client's claim, but also the amount of potential recovery and how it compares to the time and cost that a successful resolution will require. A client with a strong claim to recovery may still have trouble finding an attorney if the potential recovery is limited. See id. at 350 ("When an attorney is paid a contingency fee, however, then she will . . . pursue only those cases with a sufficiently high expected return.").

Because attorneys are sensitive to changes in the value of potential recovery, any reduction in the potential recovery, from a looming ERISA plan reimbursement claim or otherwise, will reduce the incentive of both attorney and client to bring the claim in the first place. See Brendan S. Maher & Radha A. Pathak, Understanding and Problematizing Contractual Tort Subrogation, 40 Loy. U. Chi. L.J. 49, 88 (2008) ("[U]nless a plaintiff burdened by a first-dollar recovery rule envisions a very high likelihood of a complete or near complete recovery, there is little incentive to expend resources and incur the risk associated with a lawsuit."); Karen Ertel, Insurer May Take Share of Damages Award, Supreme Court Rules, Trial, July 2006, at 92 (lawyers "simply will walk away" from personal-injury cases involving potentially large ERISA reimbursement claims) (quoting attorney).

Abrogating the common fund doctrine would have a particularly strong deterrent effect.

Although any right to reimbursement will discourage meritorious claims, the effect of eliminating the common fund doctrine would be particularly pronounced.

The common fund doctrine creates an important backstop for cases involving large insurance plan reimbursement claims. Any time the ERISA plan claims less than the entire fund, the plan member will at least be entitled to some portion of the recovery. Here, for example, U.S. Airways has claimed \$66,866, or approximately 60% of the total \$110,000 recovery. Under the common fund doctrine, U.S. Airways would thus be responsible for 60% of the attorney's fees, or around \$26,000. The leftover \$43,134 would go to McCutchen, who would pay the other 40% of attorney's fees, or around \$18,000. McCutchen would recover about \$25,000, which could go towards his ongoing out-of-pocket medical expenses.

So long as the common fund doctrine is operating, an accident victim like McCutchen can bring a claim confident that, worst-case scenario, the insurance plan would take all of his recovery. If the insurance plan is entitled to reimbursement of the full amount of recovery, the insurance plan will have to pay all of the claimaint's attorney's fees.

This outcome would be far from ideal for someone, like McCutchen, who has suffered serious injuries and is unable to work. It may be a disastrous result for many people struggling to support themselves after a serious injury. But the possibility of walking away empty handed probably would not deter most claimants. That is because the claimant's risk under a contingency fee agreement is low. He has to dedicate his time, and may be emotionally invested, but he does not have to invest cash.

Take away the common fund rule, however, and the injured claimant risks losing money even after bringing a successful claim. In McCutchen's case, for example, U.S. Airways would still recover \$66,866 from the settlement fund, leaving McCutchen with

\$43,134 before attorney's fees. But instead of splitting the attorney's fee, the entire \$44,000 fee would fall on McCutchen. McCutchen would end up owing \$866 more than his total recovery. The risk of a loss, even a small loss, would discourage many if not most claimants.

Attorneys face a similar dilemma. With the common fund rule in place, they can be certain that, so long as they are successful, they will be compensated for their effort and the expenses of prosecuting the claim. Whether it is the client or the client's insurance plan that benefits, the beneficiary will be obligated to pay the attorney's fee. Without the common fund doctrine, however, the plan could potentially claim the entire recovery. See, e.g., Walker v. Rose, 22 F. Supp. 2d 343, 345, 352 (D.N.J. 1998) (insurance company claimed entire \$600,000 settlement award; attorneys and insured received nothing). If that happens, the attorney either must waive her fee and take a loss on a claim that was pursued successfully or attempt to collect from her injured and likely judgment-proof client.

These problems do not arise in every case. Some participants will have claims against people with high insurance limits or substantial assets. And some cases may involve relatively small ERISA plan reimbursement claims. But in many cases where the reimbursement rights approach the limits of the potential recovery, both the injured party and the attorney will have little incentive to bring a legitimate claim without the security of the common fund doctrine. See, e.g., Wal-Mart Stores, Inc. Assocs.' Health

& Welfare Plan v. Wells, 213 F.3d 398, 402 (7th Cir. 2000) ("This prospect [that a plan will not have to pay its fair share of attorney's fees] might well deter a suit likely to result in a judgment or settlement not much larger than the benefits available under the plan."). In fact, the claims that are potentially the most valuable for the insurance plan, the ones where the reimbursable medical expenses are high, are the claims that will often be least attractive to the injured parties and their attorneys.

C. A reduction in legitimate claims would result in less recovery for participants generally and would have devastating effects on injured participants in particular.

In the short run, ERISA plans may benefit from elimination of the common fund doctrine. When a plan participant brings an accident claim, the plans would be able to recover all of their expenses from any recovery that the participant obtains without paying any attorney's fees.

In the long run, however, attorneys will adjust to the new rule. They will have to consider the added risks associated with bringing claims encumbered by ERISA plan reimbursement rights and advise their clients of those risks. Meritorious cases with high reimbursement values, which would have been brought were the common fund doctrine in effect, will go unpursued. ERISA plans may well end up recovering less than if the common fund doctrine still applied.

Regardless of the net impact on plan recovery, the elimination of the common fund doctrine would cost

plan participants overall. By reducing the number of legitimate claims brought by injured parties, elimination of the common fund rule would reduce the total recovery available to the participants as a group. Whether the plan alone recovered more or less in the long run, the plan and the individual participants combined would recover less.

Moreover, ERISA participants who are most in need, those who have been seriously injured, would suffer the worst of these effects. Accident victims like McCutchen are often left permanently disabled, unable to work, and in need of ongoing personal and medical care. These participants will rarely be fully compensated by their own medical insurance. Even a small recovery can be very important in those circumstances, helping injured participants defray out-of-pocket medical expenses and weather periods of unemployment.

But, as noted earlier, if the common fund doctrine does not apply, many of these accident victims will be unable to find representation at all. Attorneys, concerned about the uncertainty created by large ERISA reimbursements, will be unwilling to take on their contingency-fee cases, even if the cases would otherwise be attractive.

Those who are able to find an attorney would recover substantially less than if the common fund doctrine were in place because they will be bearing the entire burden of the costs of creating the fund while receiving only a fraction of its proceeds. Some, like McCutchen, may even find themselves worse off than if they had not brought a claim at all. D. The harms to participants that would result from eliminating the common fund doctrine are inconsistent with ERISA's purpose to protect plan participants.

ERISA was designed to protect the interests of plan participants and their dependents. 29 U.S.C. § 1001(a) (stating ERISA's purposes). Eliminating the common fund doctrine would reduce recovery for plan participants generally, and for injured participants in particular, which conflicts with that purpose.

U.S. Airways has argued that this harm to injured participants actually is consistent with ERISA's purpose because the reimbursement accrues to the benefit of other plan participants who pay lower premiums. As explained above (at 20-22), historically, reimbursement has resulted in little or no reduction in premium rates. Moreover, ERISA's legislative history indicates that Congress did not intend to sacrifice the welfare of individual injured plan members for the potential incremental benefit of the plan. Congress was motivated, at least in part, by "the absolute need that safeguards for plan participants be sufficiently adequate and effective to prevent the numerous inequities to workers under plans which have resulted in tragic hardship to so many." H.R. Rep. No. 93-533, at 9, 1974 U.S.C.C.A.N. 4639, 4647 (1974) (emphasis added).

Congress did not intend to reduce the benefits available to beneficiaries as a whole or to discourage recoveries for those beneficiaries who are most in need. Elimination of the common fund doctrine would enable ERISA plans to do just that.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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October 2012 Counsel for amicus Consumer Watchdog

AMICUS CURIAE BRIEF

No. 11-1285

OCT 2 5 2012
OPFICE OF THE CLERK

IN THE

Supreme Court of the United States

U.S. AIRWAYS, INC., IN ITS CAPACITY AS FIDUCIARY AND
PLAN ADMINISTRATOR OF THE
U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN,
Petitioner,

٧.

JAMES MCCUTCHEN AND ROSEN, LOUIK & PERRY, P.C.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF LAW PROFESSORS AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

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INTEREST OF THE AMICI CURIAE1

Amici are seven full-time legal academics who teach and write in the areas of insurance law, employee benefits law, and/or healthcare law, or who work in a clinical setting with clients who are affected by medical expense reimbursement. A list of individual amici is attached as Appendix A. Amici submit this brief to explain the broader context of how ERISA's subrogation-based right compares to other federal and state medical reimbursement schemes, in the hopes of informing the fair and consistent development of the law of ERISA.

The parties have consented to the filing of this brief. No counsel for any party authored this brief in whole or in part, and no person or entity, other than *amici* and their counsel, made a monetary contribution to the preparation or submission of this brief.

SUMMARY OF ARGUMENT

If U.S. Airways' subrogation-based rights are held to be free from any limitations on the availability of relief, that holding would place an ERISA plan's right to reimbursement at odds with nearly every other federal and state medical reimbursement scheme in the country. In virtually no area, statutory or otherwise, is a subrogee entitled to an absolute, unrestricted right to reimbursement of medical expenses from proceeds obtained from a third-party tortfeasor when the injured insured recovers less than the total amount of his damages and when the subrogee sits back and lets the insured bear the entire burden of litigation and collection, as the U.S. Airways plan did here.

The core equitable principles of prevention of double recovery and the common fund doctrine remain the bedrock upon which different models of medical expense reimbursement have developed. And there is no evidence that the continuing vitality of those principles in contemporary federal and state reimbursement models has caused an undue burden upon the courts or the coffers of private and public insurers.

ARGUMENT

It has long been recognized that subrogation is a "creature of equity" that allows the substitution of an insurer to the insured's rights so that the insurer is able to step into the shoes of the insured and acquire all the rights the insured may have against a third party. 16 Couch on Insurance § 223:8 (Lee R. Russ & Thomas F. Segalla eds., 3d ed. 2011); Johnny C. Parker. The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation, 70 Mo. L. Rev. 723, 724 (2005). Subrogation creates equitable outcomes by preventing unjust enrichment and furthering the principle of indemnity by preventing the insured from recovering twice for the same loss. Ronald C. Horn, Subrogation in Insurance Theory and Practice 24 (1964).

When Congress undertook its decade-long study of the country's private employee benefit system in the mid-1960s and early-1970s, subrogation and reimbursement clauses for medical expense claims were "virtually nonexistent." Roger M. Baron, Public Policy Considerations Warranting the Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom, 55 Mercer L. Rev. 595. 612 (2004). While the idea of subrogation and reimproperty damage has been for longstanding legal doctrine accepted at common law that was routinely applied in property insurance, insurers have only recently attempted to place reimbursement and subrogation clauses into healthcare insurance coverage agreements. Id.; see also Roger

M. Baron, Subrogation: A Pandora's Box Awaiting Closure, 41 S.D. L. Rev. 237, 238-39 (1996).

Insurers only recently began seeking "reimbursement" because the common law prohibited the assignment of personal injury claims. Baron, Denial of Reimbursement to ERISA Plans, supra, at 602 n.36. To avoid this prohibition, insurers began characterizing their claims as ones of "reimbursement," not "subrogation," in an attempt to enforce their contractual rights against the insured and collect funds obtained by the insured from a tortfeasor. Id.

As explained below, these equitable concepts are still considered by courts and legislatures in determining appropriate limits for subrogation-based rights. Some states prohibit subrogation outright in the context of medical expense reimbursement because of the historical distinction between property insurance and personal insurance, or because of the common law prohibition on assignment of personal injury claims. Other states, as well as federal statutes, limit subrogation-based rights through equity or law, depending on the nature of the action and the conduct of the parties. The prevention of double recovery continues to be recognized as the cornerstone of medical expense reimbursement.

² "Subrogation" and "reimbursement" are not synonymous terms; however, the primary objective of an insurer seeking subrogation rights is to be reimbursed for its costs that it paid on behalf of an insured under its coverage terms. 16 Couch on Insurance, supra, § 222:2 ("Reimbursement . . . technically refers to any payment back of what has been expended, without regard to the reason for the recovery or the underlying theory for repayment.").

I. NEITHER MEDICAID, MEDICARE, NOR FECA ALLOWS THE GOVERNMENT AN ABSOLUTE, UNRESTRICTED RIGHT TO THIRD-PARTY PROCEEDS.

Several federal statutory schemes other than ERISA provide for a right to reimbursement of medical expenses following a beneficiary's settlement with a liable third party. Most notably, these federal schemes include Medicaid, Medicare, and the Federal Employees Compensation Act (FECA). Although the limits on reimbursement vary among these statutes, none go so far as to allow an absolute, unrestricted right to third-party proceeds, which is the interpretation of ERISA favored by Petitioner. To allow ERISA to be interpreted in such a way will cause it to be an outlier in the landscape of federal reimbursement schemes, nearly all others of which are limited in some meaningful way.

A. Under Medicaid, State Reimbursement Rights Are Limited to Only That Portion of the Settlement or Judgment That Represents Actual Past Medical Expenses.

Medicaid provides joint federal and state funding of medical care for people who are unable to pay for their own medical costs. The Medicaid Act requires states to seek reimbursement for medical assistance paid to beneficiaries when a third party is at fault, while at the same time it prohibits states from placing a lien against the property of Medicaid recipients for the recovery of medical assistance. This Court reconciled these two apparently conflicting provisions in Arkansas Department of Health & Human Services v. Ahlborn, 547 U.S. 268 (2006), by holding that states are limited in their right to Medicaid reimbursement to only that portion of a settlement or judgment allocated to past medical expenses. Although states have enacted various models to determine the appropriate method for allocation of proceeds from a judgment or settlement under Ahlborn, what remains firmly established is the recognition that states are not entitled to unrestricted access to third-party proceeds under Medicaid.

In Ahlborn, this Court struck down Arkansas' automatic lien law. See Ahlborn, 547 U.S. at 284-85. Arkansas, in response to the obligation placed on it by 42 U.S.C. § 1396a(a)(25)(H) (requiring states to seek reimbursement from liable third parties), passed a statute by which an automatic lien for the full amount of Medicaid services provided was placed on any settlement obtained by a Medicaid recipient. Ahlborn, 547 U.S. at 272. The Medicaid recipient in Ahlborn was a nineteen-year-old college student who suffered severe physical and mental disabilities as a result of a car accident. Id. at 272-73. After her case

This Court recently granted a petition for a writ of certiorari on the issue of whether North Carolina's Medicaid reimbursement scheme is valid under the Medicaid Act and Ahlborn. Delia v. E.M.A., No. 12-98, 2012 WL 4343865 (U.S. Sept. 25, 2012). The question presented in that case is: "[W]hether N.C. Gen. Stat. § 108A-57 is preempted by the Medicaid Act's anti-lien provision as it was construed in [Ahlborn], an issue on which the North Carolina Supreme Court and the United States Court of Appeals for the Fourth Circuit are in conflict." Petition for Writ of Certiorari at i, Delia v. E.M.A., No. 12-98, 2012 WL 3027168 (U.S. July 20, 2012).

against the tortfeasor settled, the Arkansas Department of Health and Human Services (ADHS) asserted a lien against the settlement proceeds for the total cost of Medicaid payments made on the student's behalf. *Id.* at 274. The student challenged the law on the basis that it permitted recovery for injuries other than past medical expenses. *Id.*

This Court held that the Arkansas law conflicted with the Medicaid Act and limited the State's Medicaid recovery to the portion of the settlement allocated to past medical expenses. *Id.* at 282-85. The student's claim was valued at \$3,040,708.12; her case against the tortfeasor settled for \$550,000; and ADHS's expenditures totaled \$215,645.30. *Id.* at 274. The settlement with the tortfeasor therefore represented only about one-sixth of the student's total claim, and the State's right to reimbursement for Medicaid expenses was reduced proportionally, to \$35,581.47. See id. at 280-81.

Rejecting ADHS's argument that a full recovery rule was necessary to avoid settlement manipulation in which the State's portion was allocated away, this Court reasoned that there is a "countervailing concern that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others." Id. at 288. In illustration, this Court noted the reasoning employed in Flanigan v. Department of Labor & Industry. Ahlborn, 547 U.S. at 288 n.19 (citing Flanigan v. Dep't of Labor & Indus., 869 P.2d 14 (Wash. 1994)). The Flanigan court held that the State could not recover from damages awarded to the injured person's spouse for loss of consortium because the "department could not 'share in damages for which it has provided no compensation" and allowing the State to do so would be

an "absurd and fundamentally unjust" result. Ahlborn, 547 U.S. at 288 n.19 (quoting Flanigan, 869 P.2d at 17).

In the wake of *Ahlborn*, states adjusted their statutory Medicaid reimbursement frameworks to ensure appropriate allocation of third-party proceeds, especially when Medicaid recipients obtain recoveries through undifferentiated settlements, rather than tort judgments. *See*, *e.g.*, 62 Pa. Stat. Ann. § 1409(b)(11) (West 2012); N.H. Rev. Stat. Ann. § 167:14-a (2012); Cal. Welf. & Inst. Code § 14124.76 (West 2012).

Thus, under Ahlborn, states may not recoup Medicaid expenses without ensuring that the allocation process has a mechanism by which it can be determined that the allocation fairly reflects the actual portion of the settlement or judgment attributable to medical expenses.

B. The United States' Right to Reimbursement of FECA Benefits Is Capped at Four-Fifths of the Net Third-Party Recovery.

Similar to Medicaid, the United States' right to reimbursement for medical expenses paid to a federal employee under the Federal Employees' Compensation Act (FECA) is not absolute; rather, it is limited by the statutory language to four-fifths of the *net* proceeds of any settlement after deducting costs and a proportional share of attorney's fees. See 5 U.S.C. § 8132.

FECA provides compensation to federal employees who sustain work-related injuries. 5 U.S.C. §§ 8101 et seq.; see also United States v. Lorenzetti, 467 U.S.

167, 168 (1984). The Act provides coverage for medical expenses and lost wages, but does not provide compensation for other damages such as pain and suffering. *Lorenzetti*, 467 U.S. at 169; see 5 U.S.C. §§ 8102-07, 8147, 8116(c).

In Lorenzetti, this Court addressed whether a FECA beneficiary was required to reimburse the United States for medical expenses and lost wages paid to him even though his third-party recovery compensated him solely for non-economic damages, such as pain and suffering. Id. at 168. Although this Court held that the United States was entitled to reimbursement under § 8132 "regardless of whether the award or settlement is for losses other than medical expenses and lost wages," id. at 179, this Court also noted that the United States' right to reimbursement was not unlimited. Id. at 170-71. Specifically, this Court noted that § 8132 required that, at a minimum, beneficiaries are entitled to retain onefifth of the net settlement after litigation costs and attorney's fees are deducted.4 Id. at 170-71 & nn.1-2; see also 20 C.F.R. § 10.712.

That is an incorrect characterization of both § 8132 of FECA and Lorenzetti. While it is true that this Court in Lorenzetti refused to limit the United States' reimbursement to only that

In the amicus brief filed by the United States in this case, the government contends that FECA is similar to ERISA to the extent that FECA embraced equitable principles, and that despite the incorporation of equity into FECA, this Court in Lorenzetti rejected an argument analogous to Respondents' here, which sought to limit the United States' reimbursement under FECA to only that portion of a settlement or judgment representing FECA-covered economic damages. Brief for the United States as Amicus Curiae Supporting Neither Party at 17-19, U.S. Airways, Inc. v. McCutchen, No. 11-1285, 2012 WL 3864275 (U.S. Sept. 5, 2012).

Additionally, beneficiaries are entitled to retain any portion of a settlement representing damages to real or personal property, loss of consortium, wrongful death and survival actions. 20 C.F.R. § 10.711. All these monies, as well as attorney's fees and litigation costs, are subtracted from the gross recovery amount to calculate net proceeds. 20 C.F.R. § 10.712. It is from this net proceeds calculation that a beneficiary's minimum one-fifth retention and the government's maximum four-fifths recovery are calculated. *Id*.

Moreover, the United States is not entitled to reimbursement from any proceeds that an insured recovers under his own insurance — like the uninsured/underinsured motorist (UIM) insurance proceeds that McCutchen recovered in this case — because they are not considered monies recovered from a third party. 20 C.F.R. § 10.718.

This framework is designed to provide an incentive for FECA beneficiaries to pursue claims against

portion of the third-party recovery that represented FECAcovered losses, it did not do so in the context of any statutory language in FECA addressing equity. The only reference that the United States makes to the relationship between a FECA claim and equity is an observation in Lorenzetti that FECA, generally, is intended to treat federal employees "in a fair and equitable manner." Id. at 18-19 (citing Lorenzetti, 467 U.S. at 177 (quoting S. Rep. No. 93-1081, at 2 (1974))). Unlike § 502(a)(3) of ERISA, FECA says nothing about how the relief available is limited to only that relief that was typically available in equity. Contrary to the United States' attempt to analogize § 8132 of FECA with § 502(a)(3) of ERISA, FECA simply demonstrates that Congress can statutorily authorize a greater amount of recovery for reimbursement, like it did in FECA. But that does not address the issue here regarding the limits that would typically have been applicable to the claim in equity.

third parties. See Gonzalez v. Dep't of Labor, 609. F.3d 451, 455 n.2 (D.C. Cir. 2010).

C. Even Under Medicare's Reimbursement Scheme, The United States' Right to Reimbursement is Subject to a Deduction for Attorney's Fees and Includes a Relief Mechanism for Equitable Purposes.

Medicare's right to reimbursement is by far the most expansive of the federal reimbursement schemes and is unique among the federal statutory schemes in that it creates a super-priority automatic right to reimbursement when a third party is liable for the medical expenses incurred. See 42 U.S.C. § 1395y(b)(2)(B)(ii). Even so, as explained below, Medicare's reimbursement right is less expansive than the approach advocated by the ERISA plans in this case.

Medicare Secondary Payer legislation provides that Medicare will serve as a secondary payer when a beneficiary has overlapping coverage. See Zinman v. Shalala, 67 F.3d 841, 843 (9th Cir. 1995). Therefore, when a beneficiary suffers an injury that is covered by a group health plan or liability, workers' compensation, automobile, or no-fault insurance, Medicare will conditionally pay for the needed medical services, but is entitled to be reimbursed by the beneficiary for its conditional outlays should the beneficiary receive settlement from a primary insurer or third party. Id.

The Medicare statute provides for a "separate and distinct" right of recovery against any entity that is

responsible for the payment of, or has received payment for, Medicare services. *Id.* at 845; see also 42 U.S.C. § 1395y(b)(2)(B)(ii).

It is because of this separate and distinct reimbursement right that the government under Medicare, unlike Medicaid, is not limited to recovering the portion of a settlement allocated to past medical expenses. Zinman, 67 F.3d at 844. Rather, the responsibility of the beneficiary to reimburse Medicare is "ultimately defined by the scope of his own claim against the third party." Hadden v. United States, 661 F.3d 298, 302 (6th Cir. 2011) (emphasis omitted). In creating the separate right to reimbursement, decoupled from its historical ties to subrogation, Congress took the United States' reimbursement claim out of equity and, in doing so, conferred upon the United States a more expansive right to recovery. Thus, Medicare is entitled to full reimbursement from a beneficiary if that beneficiary claimed his medical expenses in full, regardless of whether or not he actually received complete compensation for the claim.

However, despite Medicare's expansive right to reimbursement, it is not, in fact, completely unlimited. Three important limits are placed on Medicare. First, beneficiaries are entitled to subtract from the Medicare reimbursement a portion of the attorney's fees paid to obtain the settlement. 42 C.F.R. § 411.37; see also Hadden, 661 F.3d at 300. Second, the United States Department of Health and Human Services is required to waive reimbursement where recovery would cause financial hardship to the beneficiary or otherwise be "against equity and good conscience." 42 C.F.R. § 1395gg(c); see also Zinman, 67 F.3d at 843 n.1. Third, when proceeds are obtained through a

judgment on the merits. Medicare reimbursement is limited to the amount allocated for past medical expenses when explicit allocation of medical and noneconomic damages is made by a court. Medicare Secondary Payer Manual, CMS Pub. 110-5, ch.7, § 50.4.4 (2008) ("The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court order on the merits of the case. If the court or other adjudicator of the merits specifically designate[s] amounts that are for payment of pain and suffering or other amounts not related to medical services. Medicare will accept the Court's designation. Medicare does not seek recovery from portions of court awards that are designated as payment for losses other than medical services."). Thus, even the most expansive federal reimbursement scheme allows for the subtraction of attorney's fees and other limitations, and recognizes the double recovery cap where the allocations are specifically designated.

In short, virtually every other federal statutory context that involves a right to reimbursement imposes some limitations on the extent of the recovery—in the form of a limitation on the amount of the lien itself and/or a requirement that the lien holder contribute to a portion of the attorney's fees. Even a statute that was passed in response to an urgent fiscal crisis—the Medicare Secondary Payer Act—places some limitations on the rights to subrogation and reimbursement. Thus, if Petitioner here has its way, ERISA will be an outlier among federal programs in which reimbursement is permitted. It is hard to imagine that, in the context of a federal statute which limits ERISA plans to "appropriate equitable relief," this is the result that Congress intended.

II. EQUITABLE PRINCIPLES ARE AP-PLIED BY STATE COURTS WHEN DE-TERMINING AN INSURER'S SUBRO-GATION-BASED RIGHTS FOR REIM-BURSEMENT OF MEDICAL EXPENSES.

The unlimited reimbursement remedy sought by Petitioner here is also at odds with the vast majority of state laws governing private insurance. If Congress were to undertake a comprehensive study of the fifty states and their treatment of reimbursement provisions in medical insurance contracts today, it would find that many states frequently use equitable principles to restrict the ability of insurers to seek reimbursement for medical expenses paid to insureds. These restrictions are achieved in several different ways: (1) applying different public policies to medical insurance coverage than to property insurance coverage; (2) ensuring that no party receives a double recovery; and (3) applying the common fund doctrine.

9

A. The Policies and Principles Underlying Subrogation-Based Rights in Property Insurance Do Not Fit Well With Medical Insurance.

Some states prohibit subrogation-based rights for medical payments altogether, ruling that the nature of personal insurance as distinct from property insurance (where subrogation first arose) does not logically or traditionally support subrogation. Others hold that subrogation in the medical context is akin to an assignment of a personal injury claim, which violates public policy.

The distinctions between property insurance and personal insurance rest on the historical concept of "indemnity." See Robert H. Jerry, II & Douglas R. Richmond, Understanding Insurance Law § 96(c) (4th ed. 2007). "Indemnity," in this sense, refers to the compensation necessary to reimburse an insured for any loss and the idea that the insured should not receive a windfall for suffering a loss. See id. § 41; Black's Law Dictionary 837 (9th ed. 2009). Based on this idea of "indemnity," subrogation by the insurer is useful to prevent an insured from receiving a "double recovery windfall" by collecting from both the insurer and the tortfeasor for a loss. See Jerry & Richmond, supra, § 96(C).

The concept of indemnity operates easily in the property insurance arena, but has a more difficult fit in personal insurance. Commentators have noted that life insurance, in particular, is viewed as more of an investment contract, rather than a contract for indemnity like property insurance, because a life insurance contract cannot provide a "dollar-for-dollar" exchange in order to make the beneficiary whole. *Id.*;

see also 1 Couch on Insurance, supra, § 1:39 (stating life insurance is not a contract of indemnity because a death is not a "loss" in the sense that the term is applied in a property insurance setting); Roger M. Baron, Subrogation on Medical Expense Claims: The "Double Recovery" Myth and the Feasibility of Anti-Subrogation Laws, 96 Dick. L. Rev. 581, 583 (1992) (noting that subrogation has its "genesis" in property insurance).

Other forms of insurance coverage, such as motor vehicle insurance, liability insurance, and accident insurance, that may provide medical coverage for personal injuries sustained by an insured, cannot be distinctly classified as property insurance or life insurance. Instead, these forms of insurance rest in a middle ground and present a difficult question for courts about subrogation-based rights. See Robert E. Keeton & Alan I. Widiss, Insurance Law, § 3.10(a)(6), at 230-31 (1988).

While there are some traces of indemnity in medical coverage situations, when looking at the incident that caused the need for medical coverage, it is "rather artificial" to take into account merely the medical expenses paid. Id. Like life insurance, the injured insured will never be fully compensated for her loss despite the fact that medical expenses are paid, because pain and suffering, disability, and limitations imposed by physical impairments or diminished earning capacity are not taken into account. See id. at 231; Jerry & Richmond, supra, § 96(c).

Some state courts have recognized these distinctions in explaining the difference between medical insurance and other forms of casualty insurance. The Oklahoma Supreme Court in Aetna Casualty and Surety Co. v. State Board for Property and Casualty Rates, 637 P.2d 1251 (Okla. 1981), examined whether certain insurance forms complied with a state statute prohibiting automobile liability insurers from seeking subrogation for medical expenses. In examining the language of the forms and declaring them inconsistent with the statute, the court remarked that:

Subrogation rights are commonly allowed when the insured sustains a fixed financial loss.

In personal insurance contracts however, the exact loss is never totally capable of ascertainment, and therefore the same reasons militating against double recovery do not obtain. The general rule, therefore, is that the insurer is not subrogated to the insured's right or the beneficiary's rights under contract of personal injury.

Id. at 1255 & n.5 (citing 3 John Appleman & Jean Appleman, Insurance Law & Practice § 167 (1967)).

The Washington Supreme Court noted the "complexities" that arise in subrogation when medical payments are involved as compared to when property loss is at issue. See Mahler v. Szucs, 957 P.2d 632, 641 (Wash. 1998) (en banc). The court recognized that, unlike in property insurance cases where the insured is fully compensated for her loss and thus has no incentive to file suit against a third-party tortfeasor, the injured insured in a personal insurance context will often sue to recover her non-economic damages, and include as an item of damages the medical expenses incurred as result of her injury. Id. For this reason the court remarked that unlike in a property insurance case, the "injured insured does not abandon its shoes, and its insurer

thus has no shoes to step into to pursue subrogation." Id.

Besides the general distinction between property insurance and more personal forms of insurance, a number of states have applied public policy considerations to prohibit an insurer's subrogation-based rights for medical expenses. For example, in Allstate Insurance Co. v. Druke, 576 P.2d 489, 492 (Ariz. 1978) (in banc), the Arizona Supreme Court found that neither equitable nor contractual subrogation rights were enforceable to recover medical expenses because it would amount to an assignment of a personal injury claim, which violated "sound public policy." The Druke court noted that medical expenses usually constitute only a portion of the insured's loss:

[i]n addition to other 'out-of-pocket' losses, such as loss of income or earning power and the costs of asserting said claim such as court costs and attorney's fees, an accident victim often suffers non-economic losses such as physical pain and mental anguish which are often not monetarily indemnifiable and never insurable.

Id. at 492. Because the repayment provision at issue in that case would have allowed the insurer to obtain full reimbursement regardless of whether the insured was fully compensated for his loss, and because it would have required the insured to return to the insurer the benefits for which he paid premiums, the provision was unenforceable as against public policy. Id.; see also Allstate Ins. Co. v. Reitler, 628 P.2d 667 (Mont. 1981) (holding medical payment subrogation clauses are invalid for public policy reasons); Maxwell v. Allstate Ins. Co., 728 P.2d 812

(Nev. 1986) (per curiam) (stating that assignment of a personal injury claim was prohibited at common law and violative of Nevada's public policy).

Thus, some scholars and state courts have recognized that subrogation-based rights should not exist at all in the medical insurance context because the concept of indemnity may not be logically extended to personal injuries for which an injured insured recovers damages from a third-party tortfeasor.

B. In States That Allow Subrogation-Based Rights for Medical Expenses, the Principles Used in Determining the Distribution of Third-Party Proceeds Center on the Prevention of Double Recovery.

Like U.S. Airways' self-funded ERISA plan, many insurance coverage provisions that are governed by state law also contain reimbursement and subrogation clauses requiring the insured to pay back the insurer for the medical expenses it paid if the insured recovers from a third party for its loss. As explained supra, subrogation and reimbursement produce equitable outcomes by preventing unjust enrichment and furthering the principle of indemnity by preventing the insured from recovering twice for the same loss. Horn, supra, at 24. Based on this principle, even when the insurer has paid the insured's medical expenses, and the insured recovers damages from a third-party tortfeasor, the right to reimbursement is not absolute. See 16 Couch on Insurance, supra, § 226:36. Rather, in order for an insurer to have a right to reimbursement, the recovery the insured receives from the third party must correspond to the

benefits paid out by the insurer. Id.; see, e.g., Ferrell v. Nationwide Mut. Ins. Co., 617 S.E.2d 790, 796 (W. Va. 2005) (allowing an insurance company to seek reimbursement because the requirement that the insured's recovery clearly duplicated the medical expense payments paid by the insurer was met).

Iowa provides a good example of this principle. In Ludwig v. Farm Bureau Mutual Insurance Co., 393 N.W.2d 143 (Iowa 1986), the Iowa Supreme Court addressed the apportionment of settlement proceeds in an action brought against a trucking company by three insureds injured in an accident by the company's truck driver. The insurer sought to enforce a conventional subrogation right to recover medical expenses it paid on behalf of the three injured insureds. The insureds claimed that they were not made whole by the settlement proceeds and therefore the insurer should not be able to recoup its medical expenses.⁵ But the court held that the principle of preventing unjust enrichment was the primary purpose of subrogation, id. at 146 (citing Restatement of Restitution § 162 (1937)), and therefore, the settlement should be apportioned accordingly. Because the amount of the settlement proceeds designated for

The "made whole" rule is an equitable insurance principle requiring that an insured be fully compensated for all its loss before the insurer acquires a right to subrogation, or reimbursement. 16 Couch on Insurance, supra, § 223:134. Most states have adopted the "made whole" rule in some fashion, but some states allow contractual language to modify the "made whole" rule. The states that have allowed for modification of this rule, have done so by treating the claim as a legal claim and enforcing contractual provision, not as a claim arising in equity. See, e.g., Wine v. Globe Am. Cas. Co., 917 S.W.2d 558 (Ky. 1996): Fortis Benefits v. Cantu, 234 S.W.3d 642 (Tex. 2007).

medical expenses was clearly set forth in the settlement documents, the insurer was permitted to recover that amount. *Id.* at 146-47.

Like Iowa, other states focus on the prevention of double recovery when determining an insurer's subrogation-based rights, whether that determination is made before or after an insured is made whole. See. e.g., Teichman v. Cmty. Hosp. of W. Suffolk, 663 N.E.2d 628 (N.Y. 1996) (holding that insurer was entitled to reimbursement under principles of subrogation but only to the extent of that portion of undifferentiated settlement that prevented double recovery); Shelter Mut. Ins. Co. v. Bough, 834 S.W.2d 637, 641 (Ark. 1992) ("[W]hile the general rule is that an insurer is not entitled to subrogation unless the insured has been made whole for his loss, the insurer should not be precluded from employing its right of subrogation when the insured has been fully compensated and is in a position where the insured will recover twice for some of his or her damages.").

C. The Common Fund Doctrine is an Equitable Principle Used by States to Limit the Ability of an Insurer to Seek Reimbursement from Insureds.

"The common fund doctrine reflects the traditional practice in courts of equity." Boeing Co. v. Van Gemert, 444 U.S. 472, 478 (1980). Under the common fund doctrine, a party who passively benefits from a fund created or preserved through litigation by another party is required to share in the cost of the litigation incurred by the insured. Dan B. Dobbs, Law of Remedies: Damages-Equity-Restitution § 4.3(4) (2d ed. 1993). The passive party shares in the cost of liti-

gation by paying a proportional share of the insured's attorney's fees and expenses in the action that the passive party financially benefitted from. 16 Couch on Insurance, supra, § 223:8. This protects against unjust enrichment which would occur if the passive party could receive reimbursement without paying the costs of obtaining it. Id.

Virtually every state has adopted the common fund doctrine in order to prevent unjust enrichment. See E. Farish Percy, Applying the Common Fund Doctrine to an ERISA-Governed Employee Welfare Benefit Plan's Claim for Subrogation or Reimbursement, 61 Fla. L. Rev. 55, 67 (2009). The common fund doctrine is applicable in a number of different contexts, ranging from insurance reimbursement, class action claims, and creation and/or preservation of a trust estate. Dobbs, supra, § 3.10(2). In the context of insurance (not including ERISA, federal statutes or state worker's compensation), at least thirty-one states have adopted the common fund doctrine in some capacity: twelve of those states have adopted some version of the common fund rule by statute that limits the ability of an insurer to be reimbursed:6 while nineteen states have applied the common fund

⁶ See Ark. Code Ann. § 23-79-146(a)(2) (2012); Colo. Rev. Stat. § 10-1-135 (2012); Ga. Code Ann. § 33-24-56.1(b)(2) (2012); Ind. Code § 34-51-2-19 (2012); Iowa Code § 668.5 (2012); Kan. Stat. Ann. § 40-3113a (2012); Ky. Rev. Stat. Ann. § 304.39-070(5) (West 2012); Me. Rev. Stat. tit. 24-A, § 2729-A (2012); Md. Code Regs. § 11-112 (2012); Minn. Stat. § 62A.095 (2012); Or. Rev. Stat. § 742.538 (2012); 42 Pa. Cons. Stat. § 2503 (2012).

doctrine where an insurer was seeking a reimbursement or subrogation claim.⁷

As Respondent notes, various courts have rejected attempts by insurers to override the common fund doctrine by contract. To highlight one recent example, in Hamm v. State Farm Mutual Automobile Insurance Co., 88 P.3d 395 (Wash. 2004), the Washington Supreme Court, in a case involving reimbursement of personal injury protection (PIP) benefits, reasoned that "the rule requiring a pro rata sharing of legal expenses is based on equitable principles and not on construction of specific policy language," indicating that the language of an insurance agreement does not matter when the insurer is seeking reimbursement. Id. at 403.

⁷ Blue Cross & Blue Shield v. Freeman, 447 So. 2d 757 (Ala. Civ. App. 1983); Sidney v. Allstate Ins. Co., 187 P.3d 443 (Alaska 2008); Lee v. State Farm Mut. Auto. Ins. Co., 129 Cal. Rptr. 271 (Cal. Ct. App. 1976); Forsyth v. S. Bell Tel. & Tel. Co., 162 So. 2d 916 (Fla. Dist. Ct. App. 1964); Wensman v. Farmers Ins. Co. of Idaho, 997 P.2d 609 (Idaho 2000); Health Cost Controls v. Sevilla, 718 N.E.2d 558 (Ill. App. Ct. 1999); Barreca v. Cobb, 668 So. 2d 1129 (La. 1996); Foremost Life Ins. Co. v. Waters, 337 N.W.2d 29 (Mich. Ct. App. 1983); Keisker v. Farmer, 90 S.W.3d 71 (Mo. 2002) (en banc); Mountain W. Farm Bureau Mut. Ins. Co. v. Hall, 38 P.3d 825 (Mont. 2001); United Servs. Auto. Ass'n v. Hills, 109 N.W.2d 174 (Neb. 1961); Amica Mut. Ins. Co. v. Maloney, 903 P.2d 834 (N.M. 1995); Wiswell v. Shelby Mut. Ins. Co., 515 N.E.2d 1214 (Ohio Ct. App. 1986); Jennings v. Nationwide Ins. Co., 669 A.2d 534 (R.I. 1996); Peppertree Resorts Ltd. v. Cabana Ltd., 431 S.E.2d 598 (S.C. Ct. App. 1993); Kline v. Eyrich, 69 S.W.3d 197 (Tenn. 2002); Allstate Ins. Co. v. Edminster, 224 S.W.3d 456 (Tex. App. 2007); Guiel v. Allstate Ins. Co., 756 A.2d 777 (Vt. 2000); Hamm v. State Farm Mut. Auto. Ins. Co., 88 P.3d 395 (Wash. 2004); State Farm Mut. Auto. Ins. Co. v. Geline, 179 N.W.2d 815 (Wis. 1970).

III. WORKERS' COMPENSATION SUBRO-GEES ARE ALSO LIMITED IN THEIR RIGHT TO REIMBURSEMENT FROM THIRD-PARTY PROCEEDS, ESPECIALLY WHEN AN INJURED EMPLOYEE RECOV-ERS UNDER HIS OWN UIM POLICY.

Like the federal and state medical expense reimbursement schemes explained above, no state workers' compensation system gives a subrogee a categorically unrestricted right to reimbursement of benefits from third-party proceeds. And, notably, the majority of states hold that workers' compensation subrogees generally have no right to reimbursement out of proceeds of a claimant's uninsured/underinsured motorist (UIM) policy, like the policy under which James McCutchen recovered some of his damages with the assistance of his privately retained counsel. Nearly all states require employers to participate in their workers' compensation systems. See Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co., 547 U.S. 651, 662-65 (2006) (explaining the nature of a state workers' compensation system as "a classic social trade-off" that gives an injured employee the right to receive limited benefits for a work-related injury or illness regardless of fault and relieves an employer of common-law and statutory tort liability) (quoting Peter M. Lencsis, Workers' Compensation: A Reference and Guide 9 (1998)). And every state workers' compensation statute provides some statutory mechanism enabling an employer, fund, or insurance carrier who has paid benefits to an injured employee to be subrogated to the employee's rights against a third party. Larson's Workers' Compensation § 116.01[1] (2007).

The primary concern of many states in distributing third-party tort proceeds between an injured employee and a workers' compensation subrogee, whether after trial or settlement, has been avoiding double recovery by the employee. To that end, several states have carefully fashioned their workers' compensation systems in various ways to specifically avoid double recovery, while at the same time ensur-

ing fairness and equity in the process.

Ohio is a good example. In Holeton v. Crouse Cartage Co., 748 N.E.2d 1111 (Ohio 2001), the Ohio Supreme Court held that the then-existing workers' compensation subrogation provision violated the takings and due process clauses of the Ohio constitution because, inter alia, it operated to allow the subrogee to take more of the claimant's tort recovery than was duplicative of the subrogee's expenditures. Id. at 1121-24. Moreover, the subrogation provision treated post-trial judgments and settlements differently: whereas a plaintiff could have special jury interrogatories designate portions of the tort recovery so they fell outside the category of reimbursable benefits, the plaintiff who settled could do no such thing and, therefore, the subrogee collected the entire settlement amount up to the amount of past and future benefits. The court found that unconstitutional. Id.

In response to *Holeton*, the Ohio legislature enacted a new subrogation provision that fixed a formula for the proportional distribution of the third-party proceeds; the formula divided the net third-party recovery so that the subrogee received a proportionate share based on its subrogation interest, while the employee received a proportionate share based on his uncompensated damages. *Groch v. Gen. Motors Corp.*, 883 N.E.2d 377 (Ohio 2008) (explaining the

legislative response to *Holeton* in the 2003 enactment of Ohio Rev. Code Ann. § 4123.931). The new formula made no distinction between proceeds from a judgment and a settlement. The Ohio Supreme Court ruled in *Groch* that the new subrogation provision was constitutional under Ohio law because the provision – while still potentially leading to some unfairness on both sides – reasonably balanced the equities between an undercompensated injured employee and a subrogee. *Id.* at 393.

Similarly, New Mexico, recognizing that one of the primary purposes of its workers' compensation subrogation mechanism is to prevent double recovery by the employee, only allows a subrogee to recoup the amount of the employee's duplicative recovery. Gutierrez v. City of Albuquerque, 964 P.2d 807, 808-10 (N.M. 1998); Chavez v. S.E.D. Lab., 14 P.3d 532, 534 (N.M. 2008).

Other states also distribute third-party proceeds through procedures that allow for apportionment and take into account the equities in bearing the costs of litigation. Kansas carves out from the subrogee's interest any damages representing loss of consortium or loss of services of a spouse, whether after trial or settlement. Kan. Stat. Ann. § 44-504 (2012). Arkansas and Minnesota allow an injured employee to keep a set portion of the net recovery protected from any right of subrogation. Ark. Code Ann. § 11-9-410 (2012) (after attorney's fees, costs, and expenses are deducted, injured claimant entitled to keep at least one-third of net recovery in all circumstances); Minn. Stat. § 176.061 (2012) (same); see also Conn. Gen. Stat. Ann. § 31-293 (West 2012) (allowing employee to keep one-third of net recovery only if subrogee does not participate in suit). In Montana, if a

subrogee chooses not to participate in the third-party action, it waives 50% of its subrogation right; plus, an employee is entitled to keep one-third of the net recovery if the amount of recovery is insufficient to provide the employee with that amount after payment of subrogation. Mont. Code Ann. § 39-71-414 (2011).

Georgia appears to go the farthest in protecting an injured employee's interest in third-party proceeds. Georgia's workers' compensation subrogation provision essentially codifies the "made-whole" doctrine and only allows a subrogee to recoup expenses when the injured employee has been fully compensated for the full amount of both economic and non-economic damages, whether by judgment or settlement. See Austell Healthcare, Inc. v. Scott, 707 S.E.2d 599, 601-02 (Ga. Ct. App. 2011) (explaining Ga. Code Ann. § 34-9-11.1).

Even in those states that give a subrogee a first lien on any third-party proceeds, the subrogee is not automatically entitled to attorney's fees, costs, and expenses incurred by the injured employee; rather those monies are either subtracted to arrive at a net recovery or the subrogee must pay a proportionate share of the fees and expenses incurred in bringing the third-party liability action. See, e.g., Ala. Code § 25-5-11 (2012) (pro rata share); Ariz. Rev. Stat. Ann. § 23-1023 (2012) (net recovery); Cal. Lab. Code § 3856 (West 2012) (net recovery); Breen v. Caesars Palace, 715 P.2d 1070 (Nev. 1986) (interpreting Nev. Rev. Stat. § 616C.215, which is silent on issue, to provide for proportionate share of attorney's fees and costs); Utah Code Ann. § 34A-2-106 (West 2012) (pro rata share); Vt. Stat. Ann. tit. 21 § 624(f) (2012) (fees and expenses divided by court).

A different approach is taken when an injured employee is compensated through the employee's own UIM policy. In that circumstance, the vast majority of states distinguish an employee-purchased UIM recovery from a third-party tort action and hold that a workers' compensation subrogee has no right to reimbursement from proceeds under an UIM policy. See 6 Larson's Workers' Compensation Law § 110.05[1] (2007). The reasoning underlying this distinction focuses mainly on the fact that most workers' compensation statutes limit subrogation to those damages available from liable third parties. and because the proceeds from an injured employee's own UIM policy are not derived from third parties, subrogation rights do not apply. See, e.g., Pinkerton's Inc. v. Ferguson, 824 N.E.2d 789 (Ind. Ct. App. 2005); Cas. Reciprocal Exch. v. Demock, 130 S.W.3d 74 (Tex. App. 2002); Am. Red Cross v. W.C.A.B. (Romano), 745 A.2d 78 (Pa. Commw. Ct. 2000), aff'd, 766 A.2d 328 (Pa. 2001). Contra Progressive Cas. Ins. Co. v. Keenan, 937 A.2d 630 (Vt. 2007) (requires proceeds from employee-purchased UIM policy to be apportioned between economic and non-economic damages, with workers' compensation carrier entitled to lien on economic damages to prevent double recovery).

IV. APPORTIONMENT OF THIRD-PARTY SETTLEMENT PROCEEDS HAS NOT RESULTED IN UNDUE BURDEN OR EXPENSE.

Given the history and prevalence of apportionment of third-party settlement proceeds pursuant to subrogation-based claims, as described above -

whether by statute under the federal reimbursement and workers' compensation schemes or by application of equitable doctrines - it is significant that no evidence appears to exist showing that apportionment has resulted in an undue burden for the courts or a financial calamity for insurers. Amicus counsel have not been able to find any statement by courts, Congress, state legislators, or scholars decrying any added burdens or expenses as a result of the apportionment processes mandated by Ahlborn, FECA, or workers' compensation schemes. Neither has criticism arisen as a result of courts' practices of holding apportionment hearings to determine the distribuof undifferentiated settlements. See, Magsipoc v. Larsen, 639 So. 2d 1038, 1043 (Fla. Dist. Ct. App. 1994) (holding that trial court is empowered as "fact-finder to determine what portion (if any) of the settlement is fairly allocable to medical costs and expenses in the equitable distribution proceeding" and remanding for further clarification of apportionment).

Furthermore, this Court has previously dismissed arguments similar to those presented by Petitioner and its Amici that requiring the allocation of settlements would result in unmanageable burdens on both the Plans and the courts. This Court rejected similar arguments made in Ahlborn by ADHS and the United States, reasoning that the "risk that parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision." Ahlborn, 547 U.S. at 288. This Court further suggested that "special rules and procedures for allocating settlements," such as those used in private in-

surance cases, "might be employed to meet concerns about settlement manipulation." Id. at 288 n.18.

Such reasoning suggests that this Court did not believe that any added burden resulting from apportionment would outweigh its value. There was no suggestion that requiring settlement proceeds to be allocated would result in either an undue additional burden to the States or an explosion of litigation in the courts. Nothing in the United States' amicus argument presented in this case compels a different conclusion, especially in light of the fact that the same "countervailing concern" – namely "that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others," id. at 288, – is also applicable here.

CONCLUSION

For the abovementioned reasons, and for the reasons stated by Respondent, the judgment of the Third Circuit Court of Appeals should be affirmed.

Respectfully submitted,

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APPENDIX A

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AMICUS CURIAE BRIEF

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In The Supreme Court of the United States

U.S. AIRWAYS, INC., IN ITS CAPACITY AS FIDUCIARY AND PLAN ADMINISTRATOR OF THE U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN,

Petitioner.

V.

JAMES E. MCCUTCHEN AND ROSEN LOUIK & PERRY, P.C.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

BRIEF OF AMICUS CURIAE THE MICHIGAN ASSOCIATION FOR JUSTICE IN SUPPORT OF RESPONDENTS

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INTEREST OF AMICUS CURIAE1

The Michigan Association for Justice (MAJ) is an association of trial attorneys who represent individual plaintiffs in legal actions throughout the State of Michigan. MAJ members commonly represent our clients through contingent fee arrangements, and of particular relevance in this case, our members regularly represent motor vehicle accident victims who must navigate Michigan's bifurcated no-fault automobile insurance system in order to protect their rights and obtain appropriate compensation for their injuries. Under this system, all of the injured person's medical expenses are paid through his or her own no-fault insurance, and consequently, the negligent driver may be sued only for noneconomic damages that cannot include any compensation for medical expenses as a matter of law.

In this context, we frequently confront ERISA plan claims for reimbursement targeted at the tort recovery of noneconomic damages, despite the fact that such a tort recovery cannot include any compensation duplicating the ERISA plan's payment of

No counsel for a party authored this brief in whole or in part. No party, or counsel for a party, made a monetary contribution intended to fund the preparation or submission of this brief. No person other than amicus curiae, its members, and its counsel have made any monetary contribution to the preparation or submission of this brief. This brief has been authored in its entirety by counsel for amicus curiae. Petitioner and Respondents have filed with the Clerk of the Court letters granting blanket consent to the filing of amicus briefs.

medical expenses. While many of us believe this type of reimbursement claim to be inequitable, district court judges often feel constrained to enforce the reimbursement provisions contained in ERISA plans without any consideration of equitable limitations on such claims. Petitioner in this case now has requested the court to adopt what amounts to a bright-line rule that the reimbursement terms of a benefit plan must be enforced without resorting to any equitable analysis of the reimbursement claim. We believe petitioner's analysis is actually backward, and contrary to petitioner's assertion, we contend that ERISA effectively forbids a plan sponsor from adopting plan terms that are inconsistent with the equitable remedies established under Section 502 of ERISA.

We also frequently confront arguments that ERISA plans are free to invade the contingent fees our members earn through their representation in automobile negligence tort actions, as petitioner claims in this case. We disagree and believe that our contingent fee agreements create equitable liens by agreement against the tort recovery that must be honored and enforced notwithstanding any contrary terms contained in an ERISA plan.

Therefore, we concur in the more detailed analysis put forward by respondent, urging the court to affirm the decision of the court of appeals, and we now write to highlight a few relevant points drawn from our experience in the Michigan no-fault context.

SUMMARY OF ARGUMENT

Section 502(a)(3) of ERISA authorizes plan participants, beneficiaries, and fiduciaries to obtain "appropriate equitable relief . . . to enforce any provisions of [ERISA] or the terms of the plan." Petitioner now essentially requests the court to adopt what amounts to a bright-line rule that the terms of a benefit plan may disclaim any equitable limitations embedded in the "appropriate equitable relief" authorized by ERISA. Petitioner seemingly believes that the terms of an ERISA plan, however inequitable and oppressive they may be, predominate over the equitable nature of the relief provided by the statute. In effect, Petitioner would read the statute to authorize equitable enforcement of inequitable plan terms. Under this theory, a plan may target its claimed right of reimbursement for medical expenses at any fund, no matter if it is unrelated to payment of medical bills, and the plan may insist that a court dishonor the contingent fee agreement of an attorney who represents a plan participant in a third party action. This theory is predicated in part on the proposition that a plan fiduciary such as petitioner must discharge its duties strictly "in accordance with the documents and instruments governing the plan" pursuant to Section 404(a)(1)(D) of the statute.

We believe this analysis is backward. Section 404(a)(1)(D) of ERISA includes a caveat limiting its mandate to plan documents insofar as they are consistent with ERISA itself. Consequently, there does not appear to be any basis for the proposition that a

plan may disclaim any features of the exclusive and comprehensive remedies authorized under Section 502. To the contrary, we believe that any plan term purporting to alter the nature of the equitable relief afforded by ERISA must be deemed unenforceable. While the plan establishes the substantive rights of participants and fiduciaries, the remedies are dictated exclusively by the statute.

We also believe that our members' contingent fee arrangements with their clients create equitable liens by agreement that are every bit as enforceable as an ERISA lien. There does not appear to be any sound basis for disregarding or dishonoring these lien rights, despite petitioner's claims to the contrary.

These issues are particularly significant to our members who represent victims of automobile negligence under Michigan's bifurcated no-fault automobile insurance system. Under Michigan law, all of the injured person's medical expenses are paid through his or her own no-fault insurance, without limitation in amount or duration. Separately, the negligent driver may be sued only for noneconomic damages that cannot include any compensation for medical expenses as a matter of law. Many of these automobile accident victims also have coverage under an ERISA health benefit plan, and disputes over reimbursement rights are common. Without the application of equitable principles, a plan apparently may dictate whether an injury victim receives any compensation from his or her no-fault insurer, and the plan may demand reimbursement of its payments from the injured person's

noneconomic tort recovery. This leaves the injured person in a position that is worse than having no ERISA benefit coverage at all.

Consequently, we request the court to affirm the decision by the court of appeals, acknowledging that equitable principles apply to ERISA reimbursement claims notwithstanding any contradictory terms contained in a benefit plan.

ARGUMENT

I. Our Experience In The Context Of The Michigan No-Fault System Illustrates The Inequity Of Permitting Unfettered Reimbursement Claims By ERISA Plans

One judge confronting the conflict between an ERISA reimbursement claim and the Michigan no-fault act has aptly noted "the adage that the only thing worse than having no insurance policy is having two." Glover v. Nationwide Mutual Fire Ins. Co., 676 F.Supp.2d 602, 606 (W.D.Mich. 2009). Indeed, while the victim of an automobile accident in Michigan may be able to take some solace in the fact that he or she has two sources of medical benefit coverage, in addition to the separate right to recover noneconomic damages for pain and suffering, the reality is that the interplay of these statutes can result in a situation where the injured person must sacrifice the entirety of the tort award to payment of medical expenses.

Every automobile owner in Michigan is required to carry no-fault automobile insurance, under which insureds recover directly from their insurers, without regard to fault, for qualifying economic losses such as medical expenses arising from motor vehicle accidents. M.C.L. § 500.3101; M.C.L. § 500.3105. These no-fault benefits include all reasonably necessary medical expenses for the injured person's care, recovery, and rehabilitation, without any limit on amount or duration. M.C.L. § 500.3107(1)(a). In exchange for ensuring certain and prompt recovery of these economic expenses, the statute also limits tort liability. M.C.L. § 500.3135; McCormick v. Carrier, 487 Mich. 180, 189 (2010). An injured person may recover in tort only for noneconomic damages, and only if the injured person has suffered death, serious impairment of body function, or permanent serious disfigurement. Id. Thus, only severely injured accident victims are eligible for tort recoveries in addition to having their medical expenses covered.

The Michigan no-fault act also enables insurers to offer, at a reduced premium, medical expense coverage that is secondary to that of other health coverage. M.C.L. § 500.3109a. However, when the terms of a no-fault insurance policy and the terms of a self-funded ERISA plan each contain valid coordination clauses, the terms of the ERISA plan prevail as a result of preemption analysis, and the no-fault coverage remains primary. Glover, supra, 676 F.Supp.2d at 614, citing American Med. Sec., Inc. v. Auto Club Ins. Ass'n of Mich., 238 F.3d 743, 754 (6th Cir. 2001).

However, in many cases the terms of the ERISA plan render it primary in priority of coverage, relieving the no-fault carrier of the obligation to pay the injured person's expenses. Citizens Ins. Co. of America v. MidMichigan Health ConnectCare Network Plan, 449 F.3d 688, 696 (6th Cir. 2006).

Unfortunately, some ERISA plans making themselves primary for medical expenses also contain terms granting the plan a right of reimbursement of all paid medical expenses from the injured person's potential noneconomic tort recovery. Under this scenario, it is entirely possible for an injured person to receive no benefit from his or her no-fault policy, and no benefit from the ERISA health benefit coverage unless and until the tort recovery fund is exhausted in reimbursing medical payments. This occurs despite the fact that the tort recovery cannot duplicate the ERISA plan's payment of medical expenses as a matter of law.

We believe that it is inequitable to assert a lien for medical benefits against a fund that cannot contain medical benefits, and we simply want to preserve our ability to make these equitable arguments, whether or not they ultimately succeed in a particular case. At the heart of the problem, however, is the proposition that the terms of an ERISA plan are always dispositive of the outcome of such a dispute, even if those plan terms seem inherently inequitable. Petitioner now seeks what amounts to a bright-line rule establishing the primacy of plan terms over any equitable limitations embedded in the "appropriate"

equitable relief" authorized by Section 502(a)(3) of ERISA. 29 U.S.C. § 1132(a)(3). We urge the court to reject this request, instead affirming the decision of the court of appeals and acknowledging that equitable principles apply to ERISA reimbursement claims notwithstanding any contradictory terms contained in a benefit plan.

II. ERISA Does Not Authorize Plan Sponsors To Adopt Plan Terms That Are Inconsistent With The Remedies Established Under Section 502

In a nutshell, petitioner and its amici argue that plan terms trump the equitable nature of the relief authorized under ERISA. As petitioner puts it: "ERISA, in short, sets up a 'straightforward rule' of 'hewing to' the contractual 'plan documents.'" Pet. Br., p. 6, citing Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan, 555 U.S. 285, 300 (2009). Of course, the Kennedy case relied on Section 404 of ERISA, requiring plan fiduciaries to act "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of [Title 1] and [Title IV] of [ERISA]." Id., quoting 29 U.S.C. § 1104(a)(1)(D) (emphasis added). Consequently, petitioner's analysis begs the question of whether plan terms disclaiming equitable limitations on equitable remedies are consistent with the provisions of ERISA.

It is well established that: "The six carefully integrated civil enforcement provisions found in § 502(a) ... provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 146 (1985). Where a statute provides such particular remedies, "a court must be chary" of altering it. Id., at 146-47. As the court has further explained in the preemption context: "The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987). As a result, ERISA preempts any state law that "duplicates, supplements, or supplants the ERISA civil enforcement remedy" because it "conflicts with the clear congressional intent to make the ERISA remedy exclusive." Aetna Health Inc. v. Davila, 542 U.S. 200, 209 (2004).

Like the preemption of state laws, there is no reason to believe that Congress meant to authorize plan sponsors to alter the remedial structure of Section 502. Congress also enumerated the requisite and optional features of plan documents in Section 402(b) of ERISA, and there is nothing in this provision or any other part of ERISA that could be construed as authorizing plans to alter the statute's exclusive remedial scheme. 29 U.S.C. § 1102(b). Simply put, the "appropriate equitable relief" authorized by Section

502(a)(3) cannot be modified or undermined by the terms of the plan document. While the plan terms establish the substantive rights of participants, the statute exclusively controls the remedies available to redress violations of those rights.

It would seem absurd to suggest that a plan may simply adopt terms that reject or override the equitable remedies of the statute in favor of preferential contract remedies, yet this appears to be the core of the argument posited by petitioner and its amici. We certainly recognize that an agreement may give rise to an equitable lien in appropriate circumstances. Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356, 363-64 (2006); citing Barnes v. Alexander, 232 U.S. 117 (1914). But this does not mean that such agreements are somehow exempt from the equitable limitations inherently applicable to "appropriate equitable relief" under Section 502, and it clearly does not convert the remedy to one sounding in contract. See Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 209-10 (2002); citing Mertens v. Hewitt Associates, 508 U.S. 248, 258 n.8 (1993). And unlike other types of agreements, plan documents must remain consistent with the statutory provisions of ERISA.

Therefore, we urge the court to reject petitioner's effort to adopt a bright-line rule authorizing plan sponsors to adopt plan terms that are inconsistent with the remedies established under Section 502.

III. A Contingent Fee Arrangement Creates An Equitable Lien By Agreement That Must Be Honored And Enforced Notwithstanding Contrary Terms Of An ERISA Plan

In addition to seeking reimbursement from the ultimate fund obtained by an injured person, petitioner has taken the position that it is entitled to invade the contingent fee earned by the attorney, claiming that its lien is paramount under Sereboff. Pet. Br., pp. 30-31. However, petitioner overlooks the fact that this situation involves another equitable lien by agreement resulting from the attorney's contingent fee agreement that is arguably superior to the lien claimed by the ERISA plan.

After all, the Sereboff decision was based on a contingent fee case. Sereboff, supra, 547 U.S. at 363-64, citing Barnes, supra, 232 U.S. at 123. There can be no dispute, therefore, that an attorney's contingent fee agreement establishes an equitable lien on the fund created by the attorney's work. Wylie v. Coxe, 56 U.S. 415, 420 (1854). It is difficult to see how such a lien could be dishonored under Sereboff.

Our members are not contracted to the ERISA plans, of course, and there is no basis for suggesting that plans may unilaterally dissolve an attorney's lien. Rather, the resolution of any such lien dispute must be made by application of equitable principles, such as the common fund doctrine, as explicated in detail by respondent. Resp. Br., pp. 26-31. This is

what equity requires, and therefore, it is what ERISA requires. 29 U.S.C. § 1132(a)(3).

CONCLUSION

For the foregoing reasons, in addition to those stated by respondent, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

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AMICUS CURIAE BRIEF

IN THE

Supreme Court of the United States

U.S. AIRWAYS, INC., IN ITS CAPACITY AS FIDUCIARY AND PLAN ADMINISTRATOR OF THE U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN, Petitioner.

22

JAMES MCCUTCHEN AND ROSEN, LOUIK & PERRY, P.C.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF AMICI CURIAE FOR THE NATIONAL ASSOCIATION OF SUBROGATION PROFESSIONALS AND THE SELF INSURANCE INSTITUTE OF AMERICA, INC. IN SUPPORT OF PETITIONER

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INTEREST OF AMICI CURIAE1

National Association of Subrogation Professionals ("NASP"). NASP is a non-profit trade association of insurance companies, third-party administrators, subrogation specialists, and attorneys practicing in the field of subrogation and recovery. NASP has approximately 2,000 members, representing more than 150 insurance companies and self-funded entities. The purpose of NASP is to create a national forum for the education, training, networking and sharing of information and, ultimately, the most effective pursuit of subrogation on an industry-wide basis.

Through NASP, members are able to retrieve, organize, and exchange information, as well as expand the use of technology to promote subrogation efforts on a cost-effective basis. The members of NASP recover hundreds of millions of dollars in health care expenditures every year for insured and self-funded employee benefit plans through subrogation and recovery practices.

NASP has an interest in whether the Employee Retirement Income Security Act ("ERISA") allows courts to use equitable principles to rewrite plan terms in order to require reimbursement. The Court's decision will have a profound impact on employee benefit plans' financial stability, which in turn will have far-reaching implications for the nation's health care system.

^{1.} No counsel for a party authored this brief in whole or in part. No party, or counsel for a party, made a monetary contribution intended to fund the preparation or submission of the brief. No one other than the Amici, their members, and their counsel made such a contribution. The parties have filed letters with the Court consenting to all amicus briefs.

Self-Insurance Institute of America, Inc. ("SIIA"). SIIA is a non-profit organization with nearly 1,000 members, serving tens of millions of health plan beneficiaries, dedicated to the advancement and protection of the self-insurance industry. SIIA's membership includes self-insured entities such as employer plan sponsors, as well as service providers such as third party administrators, reinsurance companies, and other entities that support the self-insurance business. SIIA is the only organization in the United States that exclusively represents firms, professionals, and organizations that participate in the broad spectrum of self-insurance, including self-insured group health plans.

Through SIIA, its members coordinate their views and provide practical information and recommendations to government and the public at large on a range of subjects relevant to the effective functioning of the self-insurance system, including the provisions of ERISA that concern self-insured health plans and plan participants. SIIA's mission includes rendering assistance to courts in their deliberations on significant self-insured health plan issues of broad concern to its members.

Collectively, SIIA and NASP have a strong interest in preserving their members' ability to recover plan funds from participants that accept medical benefits but then refuse to honor the reimbursement terms of their agreements after obtaining compensation from third parties through legal action or settlement. Amici's members depend on reimbursement to ensure solvency of their plans and to provide benefits to all participants at lower costs. To the extent that Amici's members are barred from seeking reimbursement according to the

terms of the plan, they might be forced to take dramatic action, such as increasing contributions, reducing benefits, or otherwise amending plan terms to protect against this growing and unnecessary risk. Each of these scenarios would have the unfortunate result of reducing the availability of health insurance for the nation's workforce.

SUMMARY OF THE ARGUMENT

The heart of ERISA is a congressional commitment to contractually defined benefits. Both plan fiduciaries and participants are entitled to rely on the express terms of the employee benefit plan. Reliance on the terms of the plan allows fiduciaries to administer the plan fairly and gives participants certainty that their benefits are secured by a binding contract.

To this end, Congress required "[e]very employee benefit plan [to] be established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). Congress also demanded ERISA plans be managed "in accordance with the documents and instruments governing the plan." 29 U.S.C. § 1104(a)(1)(D). The civil enforcement provision at issue in this case similarly reflects Congress' commitment to contractually defined benefits. In ERISA § 502(a)(3), Congress permitted civil actions "to obtain other appropriate equitable relief" to "enforce ... the terms of the plan." 29 U.S.C. § 1132(a)(3).

The Third Circuit's decision is fundamentally inconsistent with this statutory scheme. US Airways' ERISA health plan promptly and fully paid for McCutchen's medical expenses after he was injured in an automobile accident. After McCutchen recovered from third parties

an amount greater than his medical expenses, US Airways sought recovery under the plan's reimbursement clause. When McCutchen refused to reimburse the health plan according to the express terms of the contract, US Airways sought a judicial remedy "typically available in equity," Sereboff v. Mid Atl. Med. Servs. Inc., 547 U.S. 356, 361-62 (2006) (citation omitted), to "enforce ... the terms of" the reimbursement clause, 29 U.S.C. § 1132(a)(3)(B)(ii). McCutchen countered that because his tort recovery (minus the 40% claimed by his attorneys) left him with less than the medical expenses paid by the health plan, it would be "unjust enrichment" for the plan to recover the full amount of his medical expenses. The Third Circuit agreed with McCutchen that because US Airways was seeking an equitable remedy, he was entitled to raise an equitable defense.

But ERISA § 502(a)(3) provides that "appropriate equitable relief" must "enforce ... the terms of the plan," not subvert the plan. 29 U.S.C. § 1132(a)(3). Indeed, Congress emphasized throughout ERISA the primacy of enforcing plan terms. The Third Circuit's decision is incompatible with the statute's text and purpose because it subverts the terms of the plan and limits US Airways' right to an equitable lien. The Third Circuit's decision reads the phrase "enforce ... the terms of the plan" right out of the statute.

Even if the Third Circuit's construction of ERISA were correct, however, it would make no difference at all. A court of equity in the days of the divided bench would never resort to unjust enrichment where an enforceable contract existed between the parties. An enforceable contract defines the obligations of the parties, displaces

any inquiry into unjust enrichment, and protects plan fiduciaries and participants alike. Accordingly, as a matter of equity jurisprudence, it is *never* unjust to enforce valid plan terms to require reimbursement. That is especially true where, as here, the plan has already performed its obligations under the contract by paying medical expenses.

The Court must presume that Congress enacted ERISA knowing a court of equity would never resort to unjust enrichment to negate an enforceable contract. See Hall v. United States, 132 S. Ct. 1882, 1889 (2012) ("We assume that Congress is aware of existing law when it passes legislation." (citation omitted)). "[I]f Congress desired to make such an abrupt departure from traditional equity practice as is suggested, it would have made its desire plain." Hecht Co. v. Bowles, 321 U.S. 321, 330 (1944). The Court thus should not enshrine in ERISA an equitable defense that would never make a difference in a fiduciary's action to enforce an equitable lien. In other words, the Court should not adopt an interpretation of ERISA that would lead to "futile results." United States v. Am. Trucking Ass'ns, Inc., 310 U.S. 534, 543 (1940).

The Third Circuit's decision not only misinterprets § 502(a)(3), it also undermines ERISA's basic purposes and will cause significant harm to employee benefit plans and participants. Foremost, the Third Circuit's decision places contractually defined benefits in jeopardy. No longer will a contract decide the scope of employee benefits and right to reimbursement; instead, whether an ERISA plan is entitled to reimbursement will turn on pliable notions of fairness and justice depending on the views of each judge and vagaries of each jurisdiction's commitment to equity. Put simply, allowing equitable doctrines to override the

express terms of a plan undermines the integrity of written plans.

Affirming the Third Circuit's regrettable decision will predictably undermine the uniform regulatory regime Congress intended to govern employee benefit plans. Given the nature of the inquiry the Third Circuit's decision requires, the rules of the road will obviously vary judge to judge, jurisdiction to jurisdiction, and circuit to circuit. Allowing judges to override the terms of a plan based on a malleable concept of unjust enrichment thus will force administrators to tailor their employee benefit plans to the law of each jurisdiction. For some employers, the same reimbursement clause may be upheld in one jurisdiction but not another. This uncertain and costly regime will weaken the solvency of employee benefit plans and discourage employers from offering generous benefit plans in the first place.

At base, the Third Circuit's rationale makes it more difficult and expensive to sponsor and maintain employee benefit plans. Subrogation and reimbursement are cost containment measures that are critical to preserving plan assets and keeping benefits affordable in a time of escalating costs. These tools enable employers and unions to sponsor and maintain self-funded employee welfare plans by allowing them to recover paid medical expenses that are the financial responsibility of third parties. Without subrogation, plan participants would face higher costs and plans could be forced to reduce benefits. In the end, it will be plan participants who will bear the brunt of the Third Circuit's misguided decision. It should be reversed.

ARGUMENT

- I. THE THIRD CIRCUIT'S INTERPRETATION OF ERISA § 502(a)(3) SHOULD BE REVERSED.
 - A. ERISA § 502(a)(3) Does Not Incorporate Equitable Defenses That Subvert The Terms Of An Employee Benefit Plan.
- 1. ERISA is a "comprehensive and reticulated statute" governing employee benefit plans. Mertens v. Hewitt Assocs., 508 U.S. 248, 251 (1993) (quotation omitted). It is "an enormously complex and detailed statute that resolved innumerable disputes between powerful competing interests." Id. at 262. "In ERISA cases, "[a]s in any case of statutory construction, [the] analysis begins with the language of the statute And where the statutory language provides a clear answer, it ends there as well." Harris Trust & Sav. Bank v. Salomon Smith Barney Inc., 530 U.S. 238, 254 (2000).

The statutory provision at issue here, Section 502(a)(3), provides that "a participant, beneficiary, or fiduciary" may bring a civil action for "appropriate equitable relief ... to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3). US Airways' claim clearly met the statute's requirement. First, US Airways sought "appropriate equitable relief." As a "fiduciary" for purposes of Section 502(a)(3), US Airways sought a "constructive trust or an equitable lien," US Airways, Inc. v. McCutchen, 663 F.3d 671, 673 (3d Cir. 2011), a judicial remedy that is "typically available in equity," CIGNA Corp. v. Amara, 131 S. Ct. 1878, 1878 (2011) (citation omitted); see also Mertens, 508 U.S. at 256; Great-West

Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 209-10 (2002); Sereboff, 547 U.S. at 361-62. Second, there is no dispute that US Airways sought to "enforce ... the terms of" the reimbursement clause in McCutchen's employee benefit plan. Indeed, US Airways' decision to enforce the terms of the plan is the basis for the dispute between the parties. See McCutchen, 663 F.3d at 673 (explaining that "under the Plan description ... a beneficiary is required to reimburse the Plan for any amounts it has paid out of any monies the beneficiary recovers from a third party").

Accordingly, the Third Circuit should have enforced US Airways' reimbursement clause as written. Because "Congress says in a statute what it means and means in a statute what it says there, ... when the statute's language is plain, 'the sole function of the courts' ... is to enforce it according to its terms." Hartford Underwriters Ins. Co. v. Union Planters Bank, N.A., 530 U.S. 1, 6 (2000) (internal citations and quotation marks omitted). Nothing more is required to decide this case.

Courts are appropriately "reluctant to tamper with an enforcement scheme crafted with such evident care as the one in ERISA." Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 147 (1985); see also Knudson, 534 U.S. at 209; Admin. Comm. of Wal-Mart Stores, Inc. v. Shank, 500 F.3d 834, 839 (8th Cir. 2007). Indeed, this Court has repeatedly declined invitations to extend benefits and remedies not specifically authorized by ERISA. See, e.g., Knudson, 534 U.S. at 221 (refusing to "to adjust the 'carefully crafted and detailed enforcement scheme' embodied in the text that Congress has adopted" (citation omitted)); Harris Trust & Sav. Bank, 530 U.S. at 247 (explaining that "ERISA's 'comprehensive and reticulated'

scheme warrants a cautious approach to inferring remedies not expressly authorized by the text" (citation omitted)); Mertens, 508 U.S. at 262 (rejecting claim that ERISA affords a cause of action against a nonfiduciary who knowingly participates in a fiduciary breach); Russell, 473 U.S. at 144-48 (declining invitation to create an implied private cause of action for extracontractual damages because "the statutory provision explicitly authorizing a beneficiary to bring an action to enforce his rights under the plan—§ 502(a)(1)(B)—says nothing about the recovery of extracontractual damages"); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 56 (1987) (civil enforcement scheme codified at § 502(a) is not to be supplemented by state-law remedies).

2. The Third Circuit nevertheless held that the term "appropriate" in the statute "limit[s] the equitable relief available under § 502(a)(3) through the application of equitable defenses and principles that were typically available in equity." *McCutchen*, 663 F.3d at 676. This "sweeping extratextual extension" of the statute finds no support in ERISA. *Boggs v. Boggs*, 520 U.S. 833, 850 (1997). *See* Brief for Petitioner 17-19 ("Pet'r Br.").

Even if the term "appropriate" could be read to incorporate some equitable limitations on the right to an equitable lien, it would not be in a case like this. Congress would never have intended to permit any limitation on equitable recovery that subverts "the terms of the plan." 29 U.S.C. § 1132(a)(3). Section 502 itself reflects the primacy of enforcing plan terms under ERISA, referring to "the terms of the plan" or "the terms of his plan" no less than six times. As the Court has explained, "ERISA provides for equitable remedies to enforce

plan terms." Sereboff, 547 U.S. at 363. Section 502(a)(3) "does not, after all, authorize 'appropriate equitable relief' at large, but only 'appropriate equitable relief' for the purpose of ... 'enforc[ing] any provisions of ERISA or an ERISA plan." Mertens, 508 U.S. at 253. Under Section 502, then, a claim "stands or falls by 'the terms of the plan,' a straightforward rule that lets employers establish a uniform administrative scheme, [with] a set of standard procedures to guide processing of claims and disbursement of benefits." Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan, 555 U.S. 285, 300 (2009) (quoting 29 U.S.C. § 1132(a)(1)(B)).

As noted above, McCutchen wants to invoke an equitable doctrine in order to limit US Airways' recovery in direct contravention of an enforceable reimbursement clause in a valid employee benefit plan. But the Court has instructed that "courts, in fashioning 'appropriate' equitable relief, will keep in mind the 'special nature and purpose of employee benefit plans,' and will respect the 'policy choices reflected in the inclusion of certain remedies and the exclusion of others." Varity Corp. v. Howe, 516 U.S. 489, 515 (1996) (citation omitted). The Third Circuit's decision ignores the Court's admonition by reading the phrase "enforce ... the terms of the plan" out of Section 502(a)(3). See Caraco Pharm. Labs., Ltd. v. Novo Nordisk A/S, 132 S. Ct. 1670, 1684 (2012) (rejecting argument that "would all but read the term 'correct' out of the statute"). Those words have no meaning if plan participants can use equitable defenses to defeat, rather than enforce, the "terms of the plan."

The incorporation of equitable defenses that defeat otherwise enforceable plan terms also cannot be reconciled with the many other ERISA provisions that emphasize the primacy of plan terms. ERISA requires "[e]very employee benefit plan [to] be established and maintained pursuant to a written instrument," 29 U.S.C. § 1102(a)(1), "specify[ing] the basis on which payments are made to ... the plan," id. § 1102(b)(4). The plan administrator is required to manage ERISA plans "in accordance with the documents and instruments governing the plan." 29 U.S.C. § 1104(a)(1)(D). A reimbursement recovery is a payment "to" a plan under § 1102(b)(4). It is thus within the specific purview of the plan to define the basis upon which it secures reimbursement. The decision below blatantly ignores that statutory directive by eliminating, or at a minimum dramatically altering, the written requirement obligating payment to the plan.

None of the Court's cases deviates from the basic requirement that equitable relief must be for the purpose of enforcing the terms of a plan. See, e.g., Kennedy, 555 U.S. at 300. Even CIGNA, in which the Court allowed reformation of plan terms under § 502(a)(3) where there was fraud and misrepresentation, authorized equitable relief to "essentially h[o]ld CIGNA to what it had promised" in the terms of the original plan. 131 S. Ct. at 1880. See Pet'r Br. 22-24. But there was no fraud or misrepresentation in this case, see McCutchen, 663 F.3d at 679, and McCutchen seeks to use the doctrine of unjust enrichment to subvert, rather than enforce, the terms of the plan. That is simply incompatible with the text of the statute.

Contrary to the Third Circuit's conclusion, see id. at 676, neither *Knudson* nor any other decision supports its unfounded conclusion that Congress embraced the idea

that equitable defenses may be invoked to limit recovery in accordance with the terms of the plan. The Court's reference to "limitations upon its availability" in *Knudson* simply referred to whether the particular injunctive relief at issue was "typically available in equity." 534 U.S. at 211 & n.1. That issue is not in dispute here. See supra p. 7. And the fact that "Section 502(a)(3) invokes the equitable powers of the District Court," CIGNA, 131 S. Ct. at 1880, says nothing about whether Congress, under the auspices of the term "appropriate," haphazardly incorporated equitable defenses that subvert the terms of the plan. For all the reasons set forth above, Congress clearly did not.

B. Reimbursement Pursuant To An Enforceable ERISA Plan Is Never Inequitable.

Even if ERISA allowed equitable defenses to defeat enforceable plan terms, it would make no difference in this case or any other. See, e.g., Am. Trucking Ass'ns, Inc., 310 U.S. at 543 (Court will not construe a statute in a manner that leads to "futile results"). Contrary to the Third Circuit's conclusion, a court of equity would never have permitted an otherwise enforceable contract to be "defeated by equitable principles and defenses." McCutchen, 663 F.3d at 676. It is thus never inequitable to enforce valid contract terms to require reimbursement, particularly where the plan has already performed its obligations under the contract. See Pet'r Br. 41.

1. The unjust enrichment doctrine forms the basis of restitution. 1 Dan B. Dobbs, Law of Remedies § 4.1(1), at 551-52 (2d ed. 1993); id. § 4.1(3), at 564. It also forms the basis of "[b]oth the make-whole doctrine and the common fund doctrine," CGI Techs. & Solutions Inc. v. Rose, 683

F.3d 1113, 1121 (9th Cir. 2012), and has been described as "the modern designation for the older doctrine of quasicontract," 26 Samuel Williston, *A Treatise on the Law of Contracts* § 68:1, at 23-24 (4th ed. 2003).

In the days of the divided bench, a court of equity would never have resorted to unjust enrichment when an otherwise enforceable contract existed between the parties. The Restatement explains the general rule that "[a] valid contract defines the obligations of the parties as to matters within its scope, displacing to that extent any inquiry into unjust enrichment." Restatement (Third) of Restitution & Unjust Enrichment § 2(2) (2011); see also Restatement (First) of Restitution § 107 (1937) (stating that "[a] person of full capacity who, pursuant to a contract with another, has performed services or transferred property to the other or otherwise has conferred a benefit upon him, is not entitled to compensation therefor other than in accordance with the terms of such bargain").

Numerous treatises explain that a "court properly resorts to quasi-contract only in the absence of an express contract or contract implied-in-fact." 1 Williston, A Treatise on the Law of Contracts § 1:6, at 43-44; see also 26 Williston, A Treatise on the Law of Contracts § 68:1, at 22. "Where the parties did in fact contract with reference to the same general subject matter, the contract itself, interpreted in the light of its gaps and silences as well as in the light of this express provisions, should control.... [W]here there is an express contract dealing with the subject matter, no implied contract or restitution claim will be permitted." 1 Dobbs, Law of Remedies § 4.9(4), at 694. Corbin further explains that where "there is an enforceable express or implied in fact

contract that regulates the relations of the party or that part of their relations about which issues have arisen, there is not room for quasi contract." 1 Arthur Linton Corbin, Corbin on Contracts § 1.20, at 64 (rev. ed. 1993); see also 1 George E. Palmer, Law of Restitution § 4.3, at 379 (1978) ("The general policy of holding parties to their contracts supports the refusal of restitution.").

The reason for the rule is straightforward. "Contract is superior to restitution as a means of regulating voluntary transfers because it eliminates, or minimizes, the fundamental difficulty of valuation." Restatement (Third) of Restitution & Unjust Enrichment § 2 cmt. c. "Considerations of both justice and efficiency" demand "that the parties' own definition of their respective obligations ... take precedence over the obligations that the law would impose in the absence of agreement." Id. "Restitution is accordingly subordinate to contract as an organizing principle of private relationships, and the terms of an enforceable agreement normally displace any claim of unjust enrichment within their reach." Id.

Accordingly, "[c]ourts have recognized this principle and have stated their unwillingness to resort to the doctrine of unjust enrichment to override a contractual plan provision." Member Servs. Life Ins. Co. v. Am. Nat'l Bank & Trust Co., 130 F.3d 950, 957 (10th Cir. 1997); see also Zurich Am. Ins. Co. v. O'Hara, 604 F.3d 1232, 1237 (11th Cir. 2010) (refusing to "override the Plan's controlling language"); Shank, 500 F.3d at 838 (equitable principles cannot "alter the express terms of a written plan"); Albrecht v. Comm. on Emp. Benefits of Fed. Reserve Emp. Benefits Sys., 357 F.3d 62, 69 (D.C. Cir. 2004) (explaining that "there can be no claim for unjust enrichment when

an express contract exists between the parties" (citation omitted)); Bombardier Aerospace Emp. Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough, 354 F.3d 348, 362 (5th Cir. 2003) (equitable principles do not "trump[] the Plan's express language"); Singer v. Black & Decker Corp., 964 F.2d 1449, 1452 (4th Cir. 1992) (explaining that "resort to federal common law generally is inappropriate when its application would ... threaten to override the explicit terms of an established ERISA benefit plan").

In short, "one who is enriched by what he is entitled to under a contract or otherwise is not unjustly enriched." 1 Dobbs, Law of Remedies § 4.1(2), at 558. Cases adopting this line of reasoning are legion. See, e.g., Craig v. Bemis Co., 517 F.2d 677, 684 (5th Cir. 1975) ("enrichment [is] not 'unjust,' where it is allowed by the express terms of the Plan"); Admin. Comm. of the Wal-Mart Stores, Inc. v. Varco, 338 F.3d 680, 692 (7th Cir. 2003); Harris v. Harvard Pilgrim Health Care, Inc., 208 F.3d 274, 279 (1st Cir. 2000); Elmore v. Cone Mills Corp., 187 F.3d 442, 449 (4th Cir. 1999) (per curiam); United McGill Corp. v. Stinnett, 154 F.3d 168, 173 (4th Cir. 1998); Member Servs. Life Ins. Co., 130 F.3d at 957; Ryan v. Fed. Express Corp., 78 F.3d 123, 127 (3d. Cir. 1996); Cummings v. Briggs & Stratton Retirement Plan, 797 F.2d 383, 390 (7th Cir. 1986); Van Orman v. Am. Ins. Co., 680 F.2d 301, 312 (3d Cir. 1982).

This rule protects plan fiduciaries and participants alike. See Shank, 500 F.3d at 839. It protects the plan US Airways administers by enforcing the reimbursement clause in the contract. McCutchen "contributed premium payments, plus a promise to reimburse the Committee for medical expenses in the event []he was injured and received a judgment or settlement from third parties. In

exchange, []he received the certainty that the Committee would pay [his] medical bills immediately if []he was injured." Id. McCutchen thus received the benefit of the bargain when the "plan administered by US Airways paid \$66,866 for his medical expenses" resulting from his automobile accident. McCutchen, 663 F.3d at 672. Indeed, most covered persons would prefer "having their medical expenses paid up-front in third-party liability situations instead of refusing the benefits (and therefore not having to reimburse the plan) and paying their medical expenses out of their settlement." Varco, 338 F.3d at 692; see also Cutting v. Jerome Foods, Inc., 993 F.2d 1293, 1297-98 (7th Cir. 1993). McCutchen, however, never fulfilled his end of the bargain—he did not reimburse the plan after recovering medical expenses from the tortfeasor claiming it would be unjust. But there is nothing unjust about asking McCutchen to honor the agreement. Quite the opposite, this case illustrates that an ERISA plan is never unjustly enriched when a valid reimbursement clause is enforced.

If anything, it is McCutchen who would be unjustly enriched if this reimbursement clause is not enforced. "[I]t is axiomatic that a party who retains funds 'belonging in good conscience to another' is unjustly enriched at that other party's expense." Bombardier, 354 F.3d at 360; see also Restatement (First) of Restitution § 107 cmt. a (explaining that "a person is not entitled to compensation on the ground of unjust enrichment if he received from the other that which it was agreed ... the other should give in return"). Because McCutchen was "required to reimburse the Plan for any amounts it has paid out of any monies the beneficiary recovers from a third party," McCutchen, 663 F.3d at 673, "the disputed funds 'belong in good conscience' to the Plan," Bombardier, 354 F.3d at 360. His "continued

retention of these funds" after US Airways had already paid his medical expenses "unjustly enrich[es him] at the Plan's expense." Id.; see also O'Hara, 604 F.3d at 1238; Ryan, 78 F.3d at 127-28; 4 Palmer, Law of Restitution § 23.18, at 470 ("In short, principles of unjust enrichment are controlling, because in this context equitable lien is merely a remedy for preventing unjust enrichment of the insured.").

The rule that requires enforcement of the plan's terms also protects participants where there is not an enforceable reimbursement clause in the contract. Without the rule, plans could seek to recoup medical expenses from participants under a theory of unjust enrichment in the absence of an enforceable reimbursement clause. See Member Servs. Life Ins. Co., 130 F.3d at 957-58. But when participants have secured "a contractual right to payment unburdened by any right to subrogation or recoupment," "consideration of the unjust enrichment doctrine would not be proper" for the very same reason McCutchen's claim is improper here: because it would "override an express contractual provision." Id. at 958.

2. The Third Circuit simply ignored this rule despite the presence of an enforceable reimbursement clause in the contract. It concluded that "requiring McCutchen to provide full reimbursement to US Airways" consistent with the terms of the contract would result in "unjust enrichment" to US Airways. *McCutchen*, 663 F.3d at 679. The Third Circuit's application of unjust enrichment was mistaken for several reasons.

As explained above, a court properly resorts to unjust enrichment only in the absence of an enforceable

contract. The presence of an enforceable reimbursement clause here forecloses consideration of this doctrine. That is particularly true where, as here, the plan has already performed its end of the bargain. Indeed, a court of equity would not have found US Airways unjustly enriched by fulfilling its end of the bargain—paying McCutchen's emergency medical bills—and then insisting that McCutchen honor his promise to reimburse the plan because it had "rendered in full the performance that [which it] promised." 12 Corbin, Corbin on Contracts § 1104, at 12 (interim ed.).

It is also irrelevant that McCutchen was left "with less than full payment for his emergency medical bills" because his lawyers kept 40% of the recovery for themselves. McCutchen, 663 F.3d at 679. He cannot complain that the value of the employee benefit plan "has turned out to be less than he expected or that the terms of the agreement now appear to have been more advantageous to [US Airways] than to himself." 12 Corbin, Corbin on Contracts § 1104, at 12. "The fact that he may have to satisfy some part or even all of this personal obligation out of his own pocket in no way diminishes his pre-existing reimbursement obligation to the Plan vis-à-vis the funds recovered from his tortfeasor." Bombardier, 354 F.3d at 357. Indeed, "the unambiguous language of the Plan obligates h[im] to repay the benefits paid in full without a pro rata deduction for h[is] legal expenses, and thus any so-called enrichment is not unjust." Varco, 338 F.3d at 692.

The only situation in which a court of equity would have resorted to unjust enrichment was if the contract was unenforceable. In the days of the divided bench, "a claim for unjust enrichment was allowed despite the existence of an express contract between the parties, where there was an allegation that one of the parties had acted in bad faith during the formation of the contract." 26 Williston, A Treatise on the Law of Contracts § 68:1, at 16; see also 1 Corbin, Corbin on Contracts § 1.20, at 65. In other words, restitution was appropriate notwithstanding an express contract when "the transaction [wa]s rescinded for fraud, mistake, duress, undue influence or illegality, or unless the other has failed to perform his part of the bargain." Restatement (First) of Restitution § 107(1).

CIGNA vindicates this principle. See Pet'r Br. 23-24. There, the Court approved the equitable remedy of contract reformation "to prevent fraud." 131 S. Ct. at 1879. As the Court explained, "reformation of the terms of the plan, in order to remedy the false or misleading information CIGNA provided[,] ... is a traditional power of an equity court." Id.; see also id. at 1881; id. at 1884 (Scalia, J., concurring). By contrast, the Third Circuit did "not suggest that US Airways' conduct was fraudulent or dishonest in the way that Cigna's was." McCutchen, 663 F.3d at 679. The Third Circuit's application of CIGNA here to diminish "the importance of the written benefit plan" cannot be reconciled with CIGNA or basic contract principles. Id. at 678.

II. THE THIRD CIRCUIT'S DECISION UNDERMINES THE BASIC PURPOSES OF ERISA AND WILL CAUSE WIDESPREAD HARM.

ERISA embraces basic purposes necessary for employee benefit plans to function as Congress intended. Among those principles, the plan administrator has the right to have the plan's terms enforced as written. And plan administrators and participants have the right to rely on the written plan document, the uniform application of the law, freedom from undue administrative costs and burdens, and freedom from excessive litigation. The Third Circuit's decision undermines every one of these purposes and, if left undisturbed, will cause significant harm to plans and participants. See Pet'r Br. 24-29, 42-50.

A. The Third Circuit's Decision Undermines The Basic Purposes Of ERISA.

ERISA's "repeatedly emphasized purpose [is] to protect contractually defined benefits." Russell, 473 U.S. at 148; see also Varity, 516 U.S. at 515. Indeed, ERISA "is built around reliance on the face of written plan documents," Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 83 (1995), and provides that "[e]very employee benefit plan shall be established and maintained pursuant to a written instrument," 29 U.S.C. § 1102(a)(1) (emphasis added); see also Kennedy, 555 U.S. at 301; Varco, 338 F.3d at 691 (explaining that "one of ERISA's primary purposes is to ensure the integrity of written plans"); Health Cost Controls v. Isbell, 139 F.3d 1070, 1072 (6th Cir. 1997); Shank, 500 F.3d at 838-39; O'Hara, 604 F.3d at 1236; Van Orman, 680 F.2d at 312; Duggan v. Hobbs, 99 F.3d 307, 309-10 (9th Cir. 1996). Thus, courts "have held that to ensure the integrity of pension and welfare plans courts should confine the benefits to the terms of the plans as written." Varco, 338 F.3d at 692; see also Shank, 500 F.3d at 838; O'Hara, 604 F.3d at 1236.

The Third Circuit's decision undermines the integrity of written plans and contractually defined benefits. It

superimposes "equitable doctrines" on plans under the guise that ERISA requires such a result. If upheld, the ability of plan administrators and participants to rely on their written plan documents will be nullified. Courts will be free to modify the express terms of the plan even where, as here, there is no fraud or other allegation of unclean hands. Cf. CIGNA, 131 S. Ct. at 1880. Using equitable principles to "override the Plan's reimbursement provision would contravene, rather than effectuate, the underlying purposes of ERISA." Varco, 338 F.3d at 692; see also O'Hara, 604 F.3d at 1237. Such judicial modifications unnecessarily frustrate the specific requirement that every employee benefit plan be established and maintained pursuant to a written instrument that specifies the basis on which payments are made to and from the plan. "ERISA's purposes of upholding the integrity of written plans and protecting the interest and expectations of all participants and beneficiaries are best served by enforcing the [administrator's] contractual right to reimbursement." Shank, 500 F.3d at 839-40.

Another key "purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004); see also Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon, 541 U.S. 1, 17 (2004); Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9 (1987). Congress designed ERISA to ensure that plans and sponsors "would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among" jurisdictions. Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990). Otherwise, courts "might develop different substantive standards applicable to the same employer

conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." Id. "Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement." Id. "Uniformity is impossible ... if plans are subject to different legal obligations in different" jurisdictions. Egelhoff v. Egelhoff, 532 U.S. 141, 148 (2001); see also Conkright v. Frommert, 130 S. Ct. 1640, 1650-51 (2010).

The Third Circuit's decision guarantees that equitable principles will be fashioned differently in different jurisdictions. Equitable relief is, of course, a broad and malleable concept. Different courts, exercising equitable powers, will develop different versions of that relief, requiring plans to tailor their conduct to the peculiarities of the law of each jurisdiction. The version of equity to which each plan will be subject will vary depending on the jurisdiction where a case is brought and the sources a court references to determine how "equity" applies. It will badly undermine the well-defined, uniform and easily administered law that has developed and put in its place an uncertain, non-uniform, costly regime that will benefit a relatively few individuals at the cost of all plan participants.

Moreover, plan reimbursement provisions will have to be adjudicated on a case-by-case basis to ensure the plan is not unjustly enriched. Under this theory, a court must become involved any time a participant refuses to repay an ERISA plan with an otherwise enforceable reimbursement provision. That approach would frustrate Congress' goal to promote the uniform enforcement of employment benefit plans. ERISA's commitment to solvency is also clear. See, e.g., 29 U.S.C. § 1001(b) (explaining that ERISA was enacted to "protect ... the interests of participants in employee benefit plans and their beneficiaries"). ERISA is "primarily concerned with the possible misuse of plan assets and with remedies that would protect the entire plan, rather than the rights of an individual beneficiary." Russell, 473 U.S. at 142. Fiduciaries must "preserve assets to satisfy future, as well as present, claims," and must "take impartial account of the interests of all beneficiaries." Varity, 516 U.S. at 514; see also O'Hara, 604 F.3d at 1238.

The Third Circuit's decision weakens the solvency of employee benefit plans. "Reimbursement and subrogation provisions are crucial to the financial viability of self funded ERISA plans." Shank, 500 F.3d at 838. "Reimbursement inures to the benefit of all participants and beneficiaries by reducing the total cost of the Plan." O'Hara, 604 F.3d at 1237-38. "Because maintaining the financial viability of self-funded ERISA plans is often unfeasible in the absence of reimbursement and subrogation provisions like the one at issue in this case, denying ... reimbursement would harm other plan members and beneficiaries by reducing the funds available to pay those claims." Id. (citation omitted). Unfortunately, plan participants will ultimately pay the price "in the form of higher premium payments" to compensate for the inability to obtain reimbursement. Id.; see also Shank, 500 F.3d at 838.

Finally, Congress adopted ERISA to encourage employers to offer welfare benefit plans. Congress set out in ERISA to "induc[e] employers to offer benefits by assuring a predictable set of liabilities," Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 379 (2002), "but

Congress did not require employers to establish benefit plans in the first place," Conkright, 130 S. Ct. at 1648. "ERISA represents a 'careful balancing' between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans." Id. at 1649 (citation omitted). Because "maintaining the financial viability of self-funded ERISA plans is often unfeasible in the absence of reimbursement and subrogation provisions," O'Hara, 604 F.3d at 1238, the Third Circuit's decision to deny reimbursement will to some degree "discourage employers from offering welfare benefit plans in the first place," Varity, 516 U.S. at 497.

- B. The Third Circuit's Decision Will Make It More Difficult And Expensive To Sponsor And Maintain Affordable Employee Benefit Plans.
- 1. The centrality of subrogation and reimbursement as a mechanism for preserving plan assets can hardly be disputed. In an era of rising health care expenses, cost containment measures such as subrogation and reimbursement are critical to the ability to keep benefits affordable. The elimination or reduction of these recoveries would make health coverage, which is already difficult for many Americans to afford, even more expensive. One state estimated that health insurance premiums for state workers would rise between 1% and 2% if insurers' ability to enforce subrogation and reimbursement provisions were eliminated. Those sorts of premium increases in turn restrict individuals' access to coverage.

^{2.} Department of Legislative Services, Maryland General Assembly, Senate Bill 903: Contracts Between Health Maintenance Organizations and Subscribers or Groups of Subscribers Subrogation Provisions (2000), at http://mlis.state.md.us/2000rs/fnotes/bil_0003/sb0903.rtf (last visited Sept. 4, 2012).

Subrogation and reimbursement provisions are particularly important in allowing employers and unions to sponsor and maintain self-funded employee welfare plans. By allowing plans to recover paid medical expenses that are the financial responsibility of third parties, eliminating duplicative payments and preserving limited benefit dollars for the benefit of all participants, right to reimbursement provisions enable employers to offer enhanced benefits to covered participants. For selffunded plans, subrogation and reimbursement recoveries "inure[] to the benefit of all participants and beneficiaries by reducing the total cost of the plan." O'Hara, 604 F.3d at 1235. That is important because access to affordable coverage becomes even more difficult when employers are no longer able to offer welfare plans that subsidize the cost of the benefits. A survey by the United States Census Bureau showed that after four years of rising health care costs, the percentage of people receiving health benefits from their employer dropped from 63.6% in 2000 to 59.8% in 2004. See David Leonhardt, Poverty in U.S. Grew in 2004, While Income Failed to Rise for 5th Straight Year, N.Y. Times, Aug. 31, 2005, at A9.

The cost savings generated by subrogation and reimbursement, in short, are passed on to employers and employees in the form of lower premiums for insured plans, or contributions for self-funded plans. One legal scholar at the University of Chicago explained how subrogation impacts the insurance premium calculation:

An insurance company sets its rates based on historical net costs. Thus, if the insurer had one hundred policy holders in the experience period, and experienced a total of \$20,000 in claim costs, it will set its actuarial premiums at \$200 per policy holder. If, on the other hand, the insurance company experienced \$20,000 in claim costs and received \$5,000 in subrogation [or over payment reimbursement], it will set its actuarial premiums at \$150 per policy holder.

Jeffrey A. Freenblatt, Insurance and Subrogation: Where the Pie Isn't Big Enough, Who Eats Last? 64 U. Chi. L. Rev. 1337, 1355 (1997). As Judge Posner has opined: "Without subrogation, a part of the risk is shifted back to the insured. He pays more for the insurance because he retains ... a right to obtain through litigation a recovery that may actually exceed the actual loss that (after receiving insurance proceeds) he suffered." Cutting, 993 F.2d at 1297.

2. The Third Circuit's decision thus will harm employee benefit plans in several ways. First, it reduces the subrogation recoveries plans need to ensure their financial viability. See supra p. 23. The Third Circuit crafted a perverse mechanism for plan participants and beneficiaries to avoid the unambiguous terms of an ERISA plan. It encourages participants and beneficiaries to accept benefits under the plan's terms, but then to refuse to honor those terms at the expense of all other participants and beneficiaries. That will harm plans as more money is expended to pay medical expenses without the benefit of reimbursement to replenish plan funds for future benefit payments.

Second, the Third Circuit's decision will generate more ERISA litigation and dramatically increase litigation costs. In order to meet ERISA's mandate that fiduciaries administer the plan "in accordance with the documents and instruments governing the plan," 29 U.S.C. § 1104(a)(1)(D), plan fiduciaries will be forced to litigate subrogation and reimbursement claims in federal district court. No longer will ERISA litigation be a matter of determining whether the plan administrator is acting according to plan terms. Instead, each case will require a factual hearing in which the outcome depends solely upon an individual judge's notion of fairness. See supra pp. 21-22.

Third, the decision will needlessly increase the cost of operating a plan. Reducing reimbursement will damage self-funded benefit providers and generally undermine ERISA's goal of making health benefits affordable for the Nation's workforce. Because each personal injury case is different, the use of "equitable remedies" (such as unjust enrichment or the make-whole or common fund doctrines) will unnecessarily subvert plan terms. Instead of relying on the predictability offered by the plan's terms, plans will be required to thoroughly investigate and verify each element of the damages claim in order to determine, for example, if the injured plan participant is being fully compensated for medical expenses. See, e.g., Cutting, 993 F.2d at 1298.

3. The Third Circuit's decision, if allowed to stand, ultimately will harm plan participants. It will produce predictable responses by employers because of the reduction in funds available for benefit payments.

First, it could force many employers to reduce or eliminate certain benefits, increase premiums, or do both, because a plan's ability to obtain reimbursement from participants is a significant factor in establishing benefit levels and plan rates. If the plan's right to reimbursement is denied, the cost of paying for the underlying benefits falls to those who make the contributions that support plan benefits. In the absence of a predictable right to recovery, plans will be forced to protect against the resulting risk by raising rates or decreasing benefits for all participants. Plan participants that honor their obligations under plan reimbursement provisions will be forced to bear these costs.

Second, to counter an erosion of reimbursement rights, plan providers may be forced to adopt alternate approaches that shift greater burdens to plan participants. Thus, one option for plan providers faced with escalating costs would be to defer or delay payment of claims for medical expenses related to third-party negligence until the accident liability issues have been fully resolved or until third-party litigation has concluded. See, e.g., Kress v. Food Emp'rs Labor Relations Ass'n, 391 F.3d 563, 568 (4th Cir. 2004) ("Since third-party accident and sickness benefits are not even covered by the Fund, nor required by ERISA, it makes little sense to argue that ERISA precludes imposing conditions on the receipt of benefits that are in effect an interest-free loan.").

Third, to secure the certainty of recovery that judicial misinterpretation of § 502(a)(3) would deny, plans could choose to offset future benefits. In other words, a plan could add language to an existing reimbursement provision permitting the fiduciary to deny future benefits equal to the amount of money that should have been reimbursed under the terms of the plan. Or more drastically, plan sponsors might be compelled to amend their plans to exclude coverage for medical expenses

related to negligent third-party claims. See, e.g., Ryan, 78 F.3d at 127 ("ERISA neither requires a welfare plan to contain a subrogation clause nor does it bar such clauses or otherwise regulate their content."). In this situation, participants will ultimately have to pay retail rates for their medical expenses out of their own pockets because individuals cannot negotiate the more favorable group rates available to an employee benefit plan.

The net effect of all of these possible outcomes will be higher plan costs that will be shifted to all plan participants, including those plan participants that honor the terms of their agreements. This unnecessary and unwarranted shift of risk allocation would come at time when employers are finding it increasingly difficult to provide benefits to their employees. "The cost of employer-sponsored coverage is the most common reason employers cite for not offering health coverage." The Henry J. Kaiser Family Foundation, The Uninsured: A Primer: Key Facts About Americans Without Health Insurance, at 16-18 (Oct. 2011). Indeed, premiums have more than doubled since 2001. Id.

In turn, increased costs inevitably will lead to a reduction in the number of individuals that are able to afford insurance. Even a one-percent increase in costs has devastating effects: "each one percent increase in managed care plans' costs ... results in a potential loss of insurance coverage for about 315,000 individuals." Health Economics Practice, Barents Group, LLC, Impacts of Four Legislative Provisions on Managed Care Consumers: 1999-2003, at iii (1998). The Court should not endorse a rule that allows some participants to benefit from inequitable practices to the detriment of all plan

participants. It is impossible to reconcile such a rule with the plain language of § 502(a)(3), the Court's precedent, or the core purposes of ERISA.

CONCLUSION

For the reasons set forth herein, and in the Brief for Petitioner, the judgment of the court of appeals should be reversed.

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AMICUS CURIAE BRIEF

IN THE

Supreme Court of the United States

U.S. AIRWAYS, INC. IN ITS CAPACITY AS FIDUCIARY AND PLAN ADMINISTRATOR OF THE U.S. AIRWAYS, INC.

EMPLOYEE BENEFITS PLAN,

Petitioner.

V.

JAMES E. McCutchen and Rosen, Louik & Perry, P.C., Respondents.

> On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF AMICUS CURIAE OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF PETITIONER

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IN THE

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Supreme Court of the United States

No. 11-1285

U.S. AIRWAYS, INC. IN ITS CAPACITY AS FIDUCIARY AND PLAN ADMINISTRATOR OF THE U.S. AIRWAYS, INC.

EMPLOYEE BENEFITS PLAN,

Petitioner.

V

James E. McCutchen and Rosen, Louik & Perry, P.C., Respondents.

> On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF AMICUS CURIAE OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF PETITIONER

The National Coordinating Committee for Multiemployer Plans ("NCCMP") is a nonprofit, tax-exempt organization that has participated for over a quarter of a century in the development of the law applicable to employee benefit plans. The NCCMP's

Pursuant to Rule 37.6 of the Rules of this Court, the undersigned hereby state that no counsel for Petitioner or Respondents authored any part of this brief. Moreover, no person or entity other than the NCCMP made a monetary contribution to the preparation or submission of this brief.

primary purposes are to assure an environment in which multiemployer plans can continue their vital role in providing medical, pension and other benefits to working men and women, and to participate in the development of sound employee benefits legislation, regulations and policy affecting benefit plans.

The NCCMP is the only national organization devoted exclusively to protecting the interests of multiemployer plans by advocating on behalf of these plans in Congress, in the courts and in the regulatory process. Multiemployer plans provide benefits to tens of millions of American workers. Hundreds of multiemployer plans and related organizations, with a nationwide participant base located across the United States, are affiliated with the NCCMP. The plans affiliated with the NCCMP represent a majority of the participants in multiemployer plans throughout the nation and are representative of the multiemployer plan community generally. Affiliated plans are active in every major segment of the multiemployer plan universe, including the airline, building and construction, entertainment, food production, distribution and retail sales, health care, hospitality, mining, maritime, industrial fabrication, service, textile and trucking industries.

Because of this broad range of experience of the NCCMP's constituent organizations, the NCCMP believes that it is uniquely qualified to state the position of the trustees of such plans on the issues in this case. The NCCMP and its constituent groups have a strong interest in ensuring that multiemployer plans continue to have an effective, efficient and uniform

equitable remedy available to them in the federal courts to recover amounts due to the plans. Moreover, in the case of self-funded multiemployer health plans, the NCCMP and its constituent groups have a strong interest in preserving the enforceability of these plans' subrogation and right of reimbursement provisions under § 502(a)(3) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(3), and this Court's decision in Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356 (2006).

INTRODUCTION

The Court's decision in Great-West Life & Annuity Insurance Co. v. Knudson, 534 U.S. 204 (2002) defined the narrow avenue through which an ERISA plan may seek to recover funds under § 502(a)(3) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(3). Specifically, the Court held that an ERISA plan may seek restitution under § 502(a)(3) for a participant's failure to reimburse only if the plan's claim is equitable. Knudson, 534 U.S. at 213 (a plan may "seek restitution in equity, in the form of a constructive trust or an equitable lien" where the funds it seeks are specifically identifiable, belong in good conscience to the plan, and are within the possession and control of the participant or beneficiary). Prior to Knudson, beneficiaries routinely and voluntarily agreed on how and under what conditions they would satisfy a benefit

² Counsel for the Petitioner and Respondents have filed a blanket consent to the filing of amicus curiae briefs in support of either party or of neither party.

plan's equitable right to a share of payments received from responsible tortfeasors, and the vast majority of third-party recovery cases were resolved efficiently and fairly. In the rare case in which there was disagreement over the amount or fairness of the reimbursement demanded, the beneficiary and the benefit plan could negotiate a mutually agreeable resolution, or if no agreement could be reached, request that the federal courts resolve the matter. Knudson, however, more and more beneficiaries began to accept health benefits from plans and then adopt a "come get us if you can" response to attempts by benefit plans to enforce their right to reimbursement. As a consequence, efforts to enforce such rights became increasingly complex, expensive and uncertain.

With the Court's decision in Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356 (2006), a significant level of certainty was restored. Sereboff, the Court explained that an ERISA plan's right of reimbursement provision creates an "equitable lien by agreement" that is enforceable under § 502(a)(3), id. at 364-365, and concluded that the benefit plan's "action to seek reimbursement was brought to obtain equitable relief where the plan sought its recovery through a constructive trust or equitable lien on a specifically identified fund, not from the [beneficiary's] assets generally. . ." Id. at 363. While Sereboff did not restore the pre-Knudson ability of plan fiduciaries to make efficient and mutually satisfactory arrangements to perfect their right to recover amounts received from responsible tortfeasors, trustees were at least provided with concrete guidance concerning the scope of their right to

enforce subrogation and reimbursement of rights provisions. The Court in *Sereboff* did leave open the question whether equitable defenses "like the makewhole doctrine" might place limits on a benefit plan's ability under § 502(a)(3) to obtain relief. *Id.* at 368 n.2.

Although, after Sereboff, enforcement of a plan's equitable right to reimbursement continues to be complex, expensive and uncertain, fiduciaries at least have access to the equitable relief necessary to enforce plan terms. The decision below, if upheld, will undermine that modest achievement by allowing a beneficiary to expand his rights by asserting socalled equitable defenses which essentially trump the plan's express terms. As this Court made clear in CIGNA Corp. v. Amara, 563 U.S. ____, 131 S. Ct. 1866, 1879 (2011), the circumstances in which a plan's terms can be overridden are limited to those in which reformation is necessary to redress violations of ERISA or of a plan. See id. 131 S. Ct. at 1879 (2011) (Where an employer intentionally misled its employees about the benefits of its pension plan the courts may reform the plan in order "to remedy the false or misleading information [the Employer] provided."). The court below failed to honor that fundamental premise.

If allowed to stand, the decision will only lead to additional complexity, expense and uncertainty for fiduciaries when they attempt to enforce their plans' subrogation and right of reimbursement provisions—an outcome that is antithetical to ERISA's basic purpose. Notably, plans are not required to advance medical expenses for injuries caused by third parties,

and it is entirely foreseeable that they will opt not to do so if their right to reimbursement becomes riddled with "equitable defense" exceptions based on each court's perception of what is fair to a particular beneficiary. See generally Conkright v. Frommert, 130 S. Ct. 1640, 1648 (2010) ("Congress enacted ERISA to ensure that employees would receive the benefits they had earned, but Congress did not require employers to establish benefit plans in the first place. We have therefore recognized that ERISA represents a 'careful balancing between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans." (quoting Aetna Health Inc. v. Davila, 542 U.S. 200, 215 (2004)). The NCCMP submits this brief to urge the Court to reverse the decision below, and leave to multiemployer plans the remaining narrow, but extremely important, equitable remedy under § 502(a)(3).

SUMMARY OF ARGUMENT

At its core, the decision below is grounded on the overbroad premise that Congress enacted ERISA to protect the multiple and wide-ranging interests of individual plan participants and beneficiaries. In fact, the participant interests Congress sought to protect are those specified in written plans. The court further erred by expanding the equitable relief available under § 502(a)(3) to include a right to reform the terms of a plan to conform to a court's perception of what is "equitable" to a beneficiary in a given case. This would seriously limit a plan fiduciary's ability to obtain even the narrow equitable remedy prescribed in Sereboff.

It is crucial that self-funded health plans and other ERISA plans have a reliable means to utilize equitable relief under § 502(a)(3) to obtain payments that rightfully belong to the plans. The decision below, if left standing, will require plan fiduciaries to make difficult choices that do not advance the interests of participants and beneficiaries. Fiduciaries will have to expend significantly more plan assets to enforce a plan's reimbursement rights or they will be forced to agree to settle claims even where a beneficiary's third-party recovery may be well in excess of the plan's reimbursement claim, to the detriment of other plan participants. Worse, plans may conclude that it is not feasible to continue offering advance payment for medical costs resulting from injuries caused by others.

ARGUMENT

- I. THE DECISION BELOW CONFLICTS WITH ERISA'S PURPOSE OF ENSURING THAT PLAN PROVISIONS WILL BE ENFORCED UNIFORMLY IN THE FEDERAL COURTS.
 - A. The Multiple Mandates Congress Has Placed on Self-Funded ERISA Health Plans Since the Enactment of ERISA Make It More Critical Than Ever that Courts Not Lightly Engage in the Alteration of Plan Terms.

In 1981, the Court emphasized that private parties, not the Government, control the level of benefits of an ERISA plan. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981). In 1983, the Court again stressed that ERISA "sets various uniform standards,"

including rules concerning reporting, disclosure, and fiduciary responsibility, for both pension and welfare plans . . . , [but] ERISA does not mandate that employers provide particular benefits..." Shaw v. Delta Air Lines, 463 U.S. 85, 90-91 (1983) (emphasis added). In construing "appropriate equitable relief" under ERISA § 502(a)(3), the Court has cautioned against applying common law theories to alter express terms of an ERISA Plan and has instructed courts to "keep in mind the special nature and purpose of employee benefit plans." Varity Corp. v. Howe, 516 U.S. 489, 515 (1996) (internal quotation omitted). The reluctance to apply federal common law to override a plan's controlling language is grounded in the understanding that to do so typically "frustrate[s], rather than effectuate[s], ERISA's 'repeatedly emphasized purpose to protect contractually defined benefits." Zurich Am. Ins. Co. v. O'Hara, 604 F.3d 1232, 1237 (11th Cir. 2010), cert. denied, 131 S. Ct. 943 (2011) (quoting Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985)).

While the courts have adhered to this particular principle of judicial restraint, Congress and the federal agencies have undertaken a significant role in dictating the level and types of benefits that plans must provide. Beginning in 1986, when Congress first required plans to provide continuation coverage to employees and beneficiaries in the event of termination or other qualifying events, Congress, the Department of Labor, the Internal Revenue Service and the Department of Health and Human Services have steadily increased the number of mandated benefits required of self-funded health plans. ERISA,

as amended through 2009, now requires plans to provide continuation coverage to employees on qualified family or medical leave, to honor qualified medical child support orders, to provide reconstructive surgery following a covered mastectomy, to limit restrictions on benefits for preexisting conditions, to eliminate limits on hospital length of stays connected with childbirth, to establish parity between mental health and substance abuse benefits and medical benefits, and to provide that dependent college students maintain coverage in the event of medical leaves of absence from school or And the impact of the changes in enrollment. foregoing requirements pales in comparison to that of the Patient Protection and Affordable Care Act ("PPACA"). Among other things, PPACA

³ The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, 100 Stat. 82 (1986); The Family and Medical Leave Act of 1993 (FMLA), Pub. L. No. 103-3, 107 Stat. 6 (1993); The Child Support Performance and Incentive Act of 1998 (CSPIA), Pub. L. No. 105-200, 112 Stat. 645 (1998); The Women's Health and Cancer Rights Act, Pub. L. No. 105-277, Title IX, 112 Stat. 2681-436 (1998); The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (1996); 45 C.F.R. parts 160 and 164, 65 Fed. Reg. 82,462 (Dec. 28, 2000); The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), Pub. L. No. 104-204, 110 Stat. 2935 (1996); Mental Health Parity Act of 1996 (MHPA), Pub. L. No. 104-204, 110 Stat. 2944 (1996); Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Pub. L. No. 11-343, 122 Stat. 3765 (2008); Michelle's Law, Pub. L. No. 110-381, 122 Stat. 4081 (2008). This is not an exhaustive list but it does include the more burdensome changes in the law since ERISA's enactment.

⁴ Pub. L. No. 111-148, 124 Stat. 119 (2010).

requires group health plans (including self-funded health plans) to eliminate lifetime benefit limits by 2011, to phase out annual benefit limits for essential benefits by 2014, to provide dependent coverage for adult children up to age 26, to eliminate cost-sharing for preventive services and immunizations, to limit rescissions in eligibility to cases of fraud and intentional misrepresentation, to eliminate any pre-existing condition exclusions on children under age 19 by 2011, to eliminate all pre-existing condition exclusions by 2014, and to eliminate waiting periods in excess of 90 days.

This radically changed regulatory landscape for self-funded health benefit plans reinforces the need for courts to adhere to the principle that they do not sit to decide the nature or levels of benefits that must be provided by ERISA plans. More than ever, trustees of multiemployer health plans must wrestle with escalating health care costs, including the costs of complying with new expensive PPACA minimum coverage requirements, at a time when the employers in the industries that fund these plans struggle to recover from the nation's worst recession since the Great Depression. As a practical matter, the decision below, issued on the heels of the enactment of PPACA, could not come at a worse time for multiemployer health plans, their participants and beneficiaries, and their contributing employers. Thus, the NCCMP urges the Court to reject the Third and Ninth Circuits' efforts to place general equitable limitations on a fiduciary's right to seek restitution under

⁵ CGI Technologies & Solutions v. Rose, 683 F.3d 1113 (9th Cir. 2012).

the express terms of a plan providing for recovery of third-party payments.

B. Other Circuits Have Correctly Recognized that ERISA § 502(a)(3) Should Not Be Applied so as to Allow the Circumstances of an Individual Right of Reimbursement Case to Trump the Plan's Express Terms.

In Administrative Committee of the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Shank, 500 F.3d 834 (8th Cir. 2007), the Eighth Circuit considered a plan's right to recover medical expenses advanced to a beneficiary injured in an automobile accident from funds obtained by the beneficiary in a third-party settlement. Although the settlement was for \$700,000, after deducting attorney's fees and costs the plan's medical costs of \$469,216 exceeded the amount placed in the beneficiary's special needs trust. Id. at 835-836. In upholding the plan's right to enforce its reimbursement provision, the Eighth Circuit recognized that the interests of one participant cannot override the written plan document without harming all other participants:

We acknowledge the difficulty of Shank's personal situation, but we believe the purposes of ERISA are best served by enforcing the Plan as written. Shank would benefit if we denied the Committee its right to full reimbursement, but all other plan members would bear the cost in the form of higher premiums.

. . . Reimbursement and subrogation provisions are crucial to the financial viability of self-funded ERISA plans, and, as a fiduciary,

the Committee must "preserve assets to satisfy future, as well as present, claims," and must "take impartial account of the interests of all beneficiaries." *Varity Corp.*, 516 U.S. at 514.

Shank, 500 F.3d at 838 (citation and internal quotation omitted).

The NCCMP agrees with the Eighth Circuit's reasoning in Shank. See also O'Hara, 604 F.3d at 1237; Moore v. CapitalCare, Inc., 461 F.3d 1, 9 (D.C. Cir. 2006); Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot, & Wansbrough, 354 U.S. 348, 357 (5th Cir. 2003), cert. denied, 541 U.S. 1072 (2004); Administrative Comm. of Wal-Mart Stores Inc. Assocs.' Health and Welfare Plan v. Varco, 338 F.3d 680 (7th Cir. 2003), cert. denied, 542 U.S. 945 (2004). Moreover, in the context of multiemployer health plans, where increasing employee premiums to offset increased plan costs typically is not an option, a plan's reimbursement rights against third-party recoveries are critical to the maintenance of benefit levels for all participants and beneficiaries. Because funding of multiemployer health plans is primarily through employer, and occasionally employee, contributions at rates set forth in collective bargaining agreements that have durations typically of three or more years, the trustees of these plans would have to cut benefits to offset the costs of reducing a plan's reimbursement claim.

⁶ Many multiemployer health plans are funded solely by employer contributions.

The court below overlooks the practical implications of inserting so-called "equitable principles" into a health plan's subrogation and right of reimbursement provision, and in the process fails to acknowledge how its decision will adversely impact other plan participants and beneficiaries. "Because maintaining the financial viability of self-funded ERISA plans is often unfeasible in the absence of reimbursement and subrogation provisions..., denying [a plan] its right to reimbursement would harm other plan members and beneficiaries by reducing the funds available to pay those claims. . . . [A]ny inequity in this case would lie in permitting [the beneficiary] 'to partake of the benefits of the Plan and then after he had received a substantial settlement, invoke common law principles to establish a legal justification for his refusal to satisfy his end of the bargain." O'Hara, 604 F.3d at 1238 (quoting Ryan v. Federal Express, 78 F.3d 123, 127-28 (3d Cir. 1996)).

The concern regarding the link between effective enforcement of reimbursement and subrogation provisions and the preservation of plan assets for present and future claims has special significance to the self-funded multiemployer health and welfare plans which are among the NCCMP's constituency. Such plans must ensure that contributions paid in accordance with the terms of collective bargaining agreements are sufficient to cover the costs of providing benefits. A small seemingly well-funded multiemployer health benefit plan that has been providing benefits to a few hundred employees and dependents for decades could be rendered insolvent in a matter of months if suddenly hit with three or four cata-

strophic claims. While the efforts of trustees of such plans vigorously to enforce reimbursement and subrogation provisions may appear harsh when viewed from the perspective of a severely injured beneficiary, in fact these trustees are fulfilling their fiduciary duty to ensure that their plan may continue to provide benefits to all participants and beneficiaries. See ERISA § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A)("a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries; and defraying reasonable expenses of administering the plan. . ").

⁷ Prior to the enactment of PPACA, many small multiemployer plans established relatively low annual and lifetime maximums in order to control costs in the event of a catastrophic claim. The reality for beneficiaries of these plans who may have suffered a catastrophic illness or injury was that often the plan was no longer the source of providing necessary medical benefits. Although these outcomes were extraordinarily difficult on beneficiaries, they also reflect the difficult choices trustees are required to make when determining what level of benefits the plan can provide based on contribution rates outside the control of the The trustees of many of these plans are now struggling with the process of losing these cost containment provisions under PPACA. PPACA § 2711, 42 U.S.C. §§ 300gg-11, provides that by 2014 "group health plan . . . may not establish . . . lifetime limits on the dollar value of benefits for any participant or beneficiary; or annual limits on the dollar value of benefits for any participant or beneficiary."

C. The Decision Below Will Deter Plans from Offering to Advance Medical Payments for Injuries Caused by Third Parties, to the Detriment of Participants and Beneficiaries as a Group.

The value of benefits that a self-funded multiemployer health and welfare plan can provide is limited by the contribution rate paid by employers as established through collective bargaining. In addition. benefit levels are subject to factors that are largely outside of either the trustees' or the bargaining parties' control: hours worked, employer delinquencies and bankruptcies, investment performance of plan assets, medical inflation, and minimum coverage requirements and other statutory mandates, just to name a few. These factors ultimately define the amount of benefits trustees may provide plan participants and beneficiaries. Thus, while the trustees of these plans may within limits be able to determine the menu of benefits a plan may provide, they have much less control over the amount of plan assets available to pay those benefits.

Self-funded multiemployer health and welfare plans are not obligated by any law to pay medical benefits when a beneficiary is injured by a third party. If the decision below is affirmed and individ-

[&]quot;Of course, in their capacity as ERISA fiduciaries, trustees are responsible for defraying the reasonable expenses of administering the plan and must diversify investments so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so. ERISA § 404(a)(1)(A)(ii) and (C), 29 U.S.C. § 1104(a)(1)(A)(ii) and (C).

ual federal judges begin exercising "broad equitable powers" to determine whether a plan's equitable lien to enforce its contractual right to reimbursement is "appropriate equitable relief" in a given case, the result will be to significantly limit a plan administrator's ability to enforce the plan's equitable right to reimbursement. Such a difficulty, along with the complexities and uncertainties certain to follow, will undoubtedly lead to a reassessment of whether the plan should continue to pay any medical benefits when a beneficiary is injured by a third party. Thus, beneficiaries of more and more self-funded health plans likely will be placed in the unwanted situation of having no medical benefit coverage following an unexpected accident caused by a tortfeasor. Varco, 338 F.3d at 692 ("... most covered persons if given an option—would readily give up a 'common fund-type' reduction in exchange for having their medical expenses paid up-front in third-party liability situations instead of refusing the benefits (and therefore not having to reimburse the plan) and paying their medical expenses out of their settlement." (citation omitted)).

The vast majority of multiemployer self-funded health plans affiliated with the NCCMP have not agreed to pay medical benefits for injuries caused by others. The written plans commonly provide that

Absent from the long list of mandates added to ERISA's regulatory framework over the past three decades is any requirement that self-funded health plans cover injuries or illnesses caused by third parties. Nor has Congress deemed it necessary to impose limitations on right to reimbursement or subroga-

benefits are not payable if a sickness or injury is the responsibility of a third party. Recognizing that beneficiaries will need to pay for extraordinary medical expenses in the event of unexpected sickness and injuries, multiemployer plan trustees often include plan provisions to allow for advancing benefits. That advance, however, is conditioned on the beneficiary's promise to honor the plan's equitable right to reimbursement if and when the beneficiary obtains compensation from the responsible third party. See, e.g., Kress v. Food Employers Labor Relations Ass'n & United Food and Commercial Workers Health and Welfare Fund, 391 F.3d 563, 570 (4th Cir. 2004) (plan refused to pay benefits for injuries from auto accident when beneficiary refused to acknowledge equitable reimbursement right); Harris v. Harvard Pilgrim Health Care, Inc., 208 F.3d 274, 279 (1st Cir. 2000) ("[I]f the ERISA plan expressly provides that its members are obligated to reimburse the plan for 'the value of services provided, arranged, or paid for,' we do not think it can be considered 'unfair' to require plan members to abide by the agreement.").

The terms of a typical multiemployer health plan of benefits are illustrated by the plan considered by the Fourth Circuit in *Kress*:

tion provisions. Nor, for that matter, has Congress exercised its lawmaking authority to require the federal courts to adopt "the make-whole doctrine and the common fund doctrine" when considering a plan's right to enforce an equitable lien under ERISA § 502(a)(3), notwithstanding the Ninth Circuit's recent decision in *Rose*, 683 F.3d at 1119.

Waiting for a third party to pay for these injuries may be difficult. Recovery from a third party can take a long time (you may have to go to court), and your creditors will not wait patiently. Because of this, as a service to you. the Fund will pay your (or your eligible dependent's) expenses based on the understanding that you are required to reimburse the Fund in full from any recovery you or your eligible dependent may receive, no matter how it is characterized. This process is called "subrogation."... The Fund extends benefits to you and your dependents only as a service to you. The Fund must be reimbursed if you obtain any recovery from another person or entity's insurance coverage.

Kress, 391 F.3d at 566. Thus, far from having contracted to bear the risk associated with the costs of injuries caused by third parties, benefit plans typically expressly disavow any obligation to pay benefits under those circumstances.

However, recognizing the difficult circumstances presented to beneficiaries, benefit plans typically agree to advance medical costs to tide over beneficiaries in difficult times, but only if the beneficiary promises to reimburse the benefit plan later. As emphasized by the Fourth Circuit, these plan provisions

. . . broadened rather than narrowed the options of Fund participants. Nothing required [the beneficiary] to accept the subrogation option; he was free to reject it and com-

mence litigation at once, with no obligations whatever to the Fund. But if he did accept the Fund's offer, and then recovered in tort, it was not wrongful for the Fund to seek to recoup this expenditure to provide for future participants who may find themselves in similarly straitened circumstances. The Fund "must serve the best interests of all Plan beneficiaries, not just the best interest of one potential beneficiary."

Kress, 391 F.3d at 570-71 (footnote omitted) (quoting Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 234 (4th Cir. 1979)).

If the Court further restricts plans' ability to obtain a constructive trust or equitable lien, the result will not be a greater recovery for beneficiaries in personal injury lawsuits. Instead, benefit plans likely will respond by simply not advancing these payments in the first place, leaving beneficiaries to deal on their own with medical bills, creditors and delays during the uncertain and lengthy process of personal injury lawsuits. This cannot be good public policy.

Placing so-called "equitable limits" on benefit plans' reimbursement rights and granting individual federal judges discretion to apply their own brand of "broad equitable principles" to individual reimbursement cases will lead to such uncertainty and inconsistency as to force administrators to reconsider the appropriateness of advancing benefits to beneficiaries. Currently, as described above, plans typically advance benefits to beneficiaries in their time of need, based on a promise to reimburse in the

event that a future recovery is obtained. In some cases, at a point of time far in the future, the beneficiary may eventually recover a payment from the tortfeasor and be required to reimburse the plan. However, in far more common situations, the beneficiary decides not to pursue an action against the responsible tortfeasor, or based on the uncertainties and expense of litigation agrees to a settlement which is less than full compensation. In these common scenarios, the beneficiary retains the benefit of having had his medical expenses paid on his or her behalf. This benefit will be lost if self-funded health plans stop advancing medical costs because they cannot effectively enforce an equitable claim for reimbursement.

D. The Typical Subrogation and Right of Reimbursement Provisions in Self-Funded Multiemployer Health Plans Are Carefully Drawn to Protect against Risks to the Collective Interests of Participants and Beneficiaries and Are Administered so as to Accommodate Beneficiaries to the Extent Possible; the Decision Below Would Negate Those Protections and Benefits.

Self-funded multiemployer health and welfare plans generally incorporate subrogation and right of reimbursement provisions that strive to be "airtight" in terms of the obligations of beneficiaries who accept advanced payment of medical expenses.¹⁰ In

¹⁰ Most self-funded multiemployer health plans include provisions that establish the plans' right of subrogation and right to reimbursement. Although the terms are often used inter-

fact, many of these plans have subrogation and right of reimbursement provisions that are quite similar to the one found in the Petitioner's plan. See U.S. Airways, Inc. v. McCutchen, 663 F.3d 671, 673 (2012). Generally, such plan provisions will unequivocally provide: (1) that the plan's primary purpose is to provide benefits that are not covered by a third party; (2) that the plan is only obligated to provide covered benefits resulting from the actions of a third party that exceed any amounts recovered from another party regardless of whether the amount recovered is designated to cover medical expenses: (3) that amounts recovered by a beneficiary from another party are assets of the plan by virtue of the plan's subrogation interest and are not distributable to any person or entity without the plan's release of its subrogation interest; and (4) that the plan has a right to first reimbursement out of any recovery without reduction for attorneys' fees, costs, expenses or damages claimed by the beneficiary and regardless of whether the beneficiary is made whole or recovers only part of his or her damages.

changeably and are often confused, they technically involve different concepts. The right of subrogation allows the plan to step into the shoes of the beneficiary so as to have the benefit of the beneficiary's rights and remedies against a tortfeasor. The right to reimbursement provides the plan with a lien on property, a beneficiary's settlement for example, that prevents distribution prior to satisfaction of the plan's lien. As a practical matter, when dealing with third party responsibility, self-funded multiemployer health plans rarely exercise a true right of subrogation, such as by filing suit against the tortfeasor. Instead, such plans typically rely on their right to reimbursement. Accordingly, in this brief, the NCCMP has focused on the latter process.

There are at least three reasons why a board of trustees will go to such lengths to protect a health and welfare plan's reimbursement rights. First, a number of courts of appeal have demonstrated a willingness to interpret arguably ambiguous reimbursement provisions using state insurance law principles or "unique" common law equity principles as their guide. See Cagle v. Bruner, 112 F.3d 1510, 1522 (11th Cir. 1997) ("[T]he make whole doctrine exists because parties to an insurance contract do not always explicitly address what happens when the insurer pays less than the insured's total loss, and the insured achieves a recovery from a third party. The effect of the doctrine is to imply into ambiguous insurance contracts (including ERISA plans) a default provision governing that situation."); Waller v. Hormel Foods Corp., 120 F.3d 138, 141-142 (8th Cir. 1997) (reading the common fund doctrine into ERISA plan's subrogation provision). Therefore, specificity is a necessity. Second, the trustees seek to establish an unambiguous equitable basis for the plan's right to reimbursement that satisfies the requirements of ERISA § 502(a)(3).11 Third, the trustees seek to avoid having the plan's amount of recovery exposed to factors outside the trustees' control. A non-exhaustive

[&]quot;It is the NCCMP's understanding that many boards of trustees of multiemployer health and welfare plans amended their plans' subrogation and right of reimbursement provisions soon after the Court issued its decision in *Knudson*. Other boards of trustees amended their plans' right of reimbursement provisions soon after certain Circuit Courts began reading the common-fund doctrine or make-whole doctrine into a self-funded plan's arguably ambiguous right of reimbursement provision.

list of such factors may include how settlements or judgments designate payments, the quality of legal representation of the beneficiary or third party, state laws that may limit recovery, the depth of the pockets of the third party, the level of insurance of the third party, any contributory negligence or comparative negligence on the part of the beneficiary, the vagaries of individual jury verdicts, any immunity defenses of the third party, or the unwillingness of the beneficiary's attorney to reduce his or her fees.

Thus, it would be incorrect to assume that trustees of multiemployer health and welfare plans have incorporated airtight subrogation and right of reimbursement provisions out of an unwillingness to compromise a plan's claims. Rather, the manner in which these provisions are drafted reflects the trustees' recognition that it is not in the collective interest of participants and beneficiaries to have plan assets exposed to factors outside the trustees' control.

As a practical matter trustees often agree to reduce a plan's equitable lien against a participant's third-party recovery. Many multiemployer plans have established formal procedures that govern when a compromise will be appropriate, and the amount of the lien reduced. For example, the trustees may give the plan's attorney authorization to reduce a lien by a certain fixed percentage if the participant's attorney agrees to reduce his or her fee by a certain percentage. Trustees may also agree to settle a claim for the amount of a beneficiary's third-party recovery, less the amount of the beneficiary's attorney's fees and costs. In other cases, the full board of trustees

will consider a beneficiary's request that the plan reduce its lien at a meeting of the full board in accordance with ERISA's claims procedures. 29 C.F.R. § 2560.503-1(h) (Appeal of adverse determinations). Although these procedures allow the trustees to consider the beneficiary's circumstances and to weigh the beneficiary's interests against the interests of the plan and other participants and beneficiaries, the outcome is typically determined exclusively by the trustees. Cf. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 (1998) (In the case of a denial of benefits under ERISA § 502(a)(1)(B), where the plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan, the determination of the administrator is reviewed under the abuse of discretion standard). The decision below would take the process of compromising claims out of the hands of the plan's fiduciaries and allow individual federal judges to apply their own brand of "broad equitable principles" to each case.

II. IF THE COURT ENDORSES THE REASON-ING UNDERLYING THE DECISION BELOW, IT WILL LEAD TO UNCERTAINTY AND NON-UNIFORM ENFORCEMENT OF ERISA PLAN PROVISIONS.

It would be wrong to assume that, if the Third and Ninth Circuits' holdings are upheld, the cost to self-funded health plans will be limited to reductions in reimbursement deemed appropriate by federal courts applying "equitable principles" to individual cases. The court below deemed the Petitioner's "practical concern that the application of equitable

principles will increase plan costs and premiums . . . unsubstantiated by the circumstances of this case." *McCutchen*, 663 F.3d at 679. This short-sighted view of the implications of the court's decision misses the mark.

It is entirely predictable that, if the decision below is upheld, plans will be confronted with every purported equitable defense under the sun, regardless of the circumstances underlying any particular case. During the time between the Court's decisions in Knudson and Sereboff, there was a high degree of uncertainty regarding the extent to which plans could continue to seek equitable relief under § 502(a)(3) to enforce their right to reimbursement. During this period of uncertainty, it became commonplace for beneficiaries to accept health benefits from plans and then adopt a "come get us if you can" response to the legitimate assertion that a benefit plan had an equitable claim to a share of payments recovered from third parties. Even after Sereboff, enforcement of an equitable right to reimbursement continues to be complex and expensive for benefit plans because many beneficiaries simply refuse to honor their obligation to reimburse.

There is little doubt that the Third Circuit below and the Ninth Circuit in *Rose* have given beneficiaries and their attorneys an open invitation to respond to a plan's reimbursement claim with an "everything but the kitchen sink" equitable defense strategy. For example, the Third Circuit left open the question of whether the "make-whole" doctrine could be used as an equitable defense to the plan's reimbursement claim. *McCutchen*, 663 F.3d at 676 n.2. The Circuit

Court merely directed the district court that when it "exercise[s]... its discretion to fashion 'appropriate equitable relief,'" it should consider "factors such as the distribution of the third-party recovery between McCutchen and his attorneys..., the nature of their agreement, the work performed, and the allocation of costs and risks between the parties to this suit...

" Id., at 679. The Ninth Circuit in Rose exhibited the same unwillingness to provide plans and beneficiaries with a clear understanding of what would be "appropriate" equitable relief:

[N]otwithstanding the express terms of the Plan disclaiming the application of the makewhole doctrine and the common fund doctrine, it is within the district court's broad equitable powers under § 502(a)(3) not to give those provisions a controlling weight in fashioning "appropriate equitable relief." . . . We express no opinion at this time on what result the district court, in exercising those powers should reach. . .

Rose, 683 F.3d at 1124.

Without placing any qualifiers on the district courts' "broad equitable powers," the Third and Ninth Circuits invite beneficiaries and their attorneys to propose a host of equitable defenses that may or may not pass muster with the lower courts, but will certainly increase the costs to plans in enforcing subrogation or reimbursement rights and will likewise increase the degree of uncertainty concerning meaningful recoveries. The NCCMP further fears that, by inviting the district courts to apply so-called equitable principles and defenses in right of reimburse-

ment cases, the decision below will invite challenges from plan participants and beneficiaries in a broader range of cases involving both ERISA welfare plans and ERISA pension plans. Prior to the Court's decision in Knudson, for example, the lower federal courts had no difficulty creating an unjust enrichment remedy as part of the federal common law, permitting benefit plans to seek restitution against third parties who wrongfully or mistakenly received money from an ERISA plan. See, e.g., Heller v. Fortis Benefits Ins. Co., 142 F.3d 487, 495 (D.C. Cir. 1998); Luby v. Teamsters Health, Welfare & Pension Trust Funds, 944 F.2d 1176, 1186 (3d Cir. 1991); Blue Cross & Blue Shield of Ala. v. Weitz, 913 F.2d 1544, 1548-49 (11th Cir. 1990); Provident Life & Accident Ins. Co. v. Waller, 906 F.2d 985, 994 (4th Cir. 1990). However, after Knudson, the lower courts began to question whether an ERISA benefit plan could sue under § 502(a)(3) to recover benefits in any context. See, e.g., Cooperative Benefit Admin'rs, Inc. v. Ogden, 367 F.3d 323 (5th Cir. 2004) (holding benefit plan had no remedy under § 502(a)(3) to recover pension benefits advanced to participant waiting for social security disability payments to begin); Honolulu Joint Apprenticeship & Training Comm. v. Foster, 332 F.3d 1234 (9th Cir. 2003) (holding benefit plan had no remedy under § 502(a)(3) to recover costs of apprenticeship training); Trustees of the AFTRA Health Fund v. Biondi, 303 F.3d 765, 771 (7th Cir. 2002) (noting district court's dismissal of benefit plan's action under § 502(a)(3) to recover fraudulently obtained benefit payments). The very narrow equitable remedy of constructive trust or equitable lien prescribed by the Court in Knudson and Sereboff is vital to any

benefit plan seeking to recover plan assets from third parties.

CONCLUSION

For the foregoing reasons, the NCCMP respectfully urges the Court to reverse the decision below.

Respectfully submitted,

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AMICUS CURIAE BRIEF

No. 11-1285

Supreme Court U.S. FILED

OCT 1 8 2012

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In The

Supreme Court of the United States

U.S. AIRWAYS, INC., in its capacity as Fiduciary and Plan Administrator of the U.S. AIRWAYS, INC. EMPLOYEE BENEFITS PLAN,

Petitioner.

V.

JAMES MCCUTCHEN and ROSEN, LOUIK & PERRY, P.C.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

BRIEF OF AMICUS CURIAE OF THE PENNSYLVANIA ASSOCIATION FOR JUSTICE IN SUPPORT OF RESPONDENTS

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STATEMENT OF INTEREST OF AMICUS CURIAE¹

The Pennsylvania Association for Justice is a non-profit organization with a membership of over 2,300 men and women of the trial bar of the Commonwealth of Pennsylvania. For over forty years, the Association has promoted the rights of individual citizens by advocating the unfettered right to trial by jury, full and fair compensation for innocent victims, and the maintenance of a free and independent judiciary.

The Association has a strong interest in the application of equitable principles when determining the amount of third-party reimbursement from a judgment or settlement. It believes that equitable reimbursement fosters the pursuit of meritorious cases, the resolution of cases through settlement, and the fair distribution of funds to all stakeholders in a tort settlement. The Association submits this brief to advance that perspective.

This brief is submitted with the consent of the parties. It was prepared on behalf of the Pennsylvania Association for Justice by its undersigned counsel. It was not authored in whole or in part by counsel for any party. No person or entity other than the Pennsylvania Association for Justice or its counsel made a monetary contribution to the preparation or submission of the brief.

SUMMARY OF ARGUMENT

The Pennsylvania Association for Justice fully supports Respondents' argument that Section 502(a)(3) of the Employee Retirement Income Security Act ("ERISA") allows courts to consider equity when determining the scope of an ERISA plan's reimbursement rights against a tort settlement. It writes separately to emphasize that Respondents' analysis is well supported by practical considerations. Considering equity heightens the likelihood that meritorious cases will be pursued and that cases will be settled rather than tried to a jury (saving the litigation system the burdens of trial). At the same time, Petitioner's hardline approach reduces the likelihood that third-party payors will obtain reimbursement in individual cases. Petitioner's approach also invites conflict as plaintiffs are incentivized to challenge third-party reimbursement through other channels. For these reasons, and those set forth in Respondent's brief, the judgment of the United States Court of Appeals for the Third Circuit should be affirmed.

ARGUMENT

The brief of Respondents amply states the reasons this Court should affirm the Third Circuit's decision. This submission additionally highlights the

salutary benefits of an equitable approach to resolving third-party claims, and suggests that Petitioner and supporting amici have missed crucial points when arguing to the contrary.

An equitable approach to third-party reimbursement promotes the filing of meritorious cases.

Third-party reimbursement is an ever-present component of personal injury litigation. It happens routinely that people suffer injury through the tortious conduct of others. When this happens, governmental or private ERISA plans often pay for resulting medical care. If the injured person sues, and obtains a settlement or judgment, it is well-established that such third parties are entitled to some level of reimbursement for their payments on the injured person's behalf. As such, a first step in evaluating a potential claim is determining whether any third parties have paid for the injured person's medical care.

Plaintiffs' lawyers must determine the existence of third-party claims initially for process reasons. For example, if a complaint is actually filed, those third-party payors must be notified so they may assert their rights against a resulting fund. The existence of third-party payments also may shape the proofs to be introduced at trial regarding past medical expenses. In addition, resolving of third-party claims can be

complex and hence negotiation between plaintiff and the third party may need to commence long before settlement of the tort claim itself; nobody wants a settlement complicated by last-minute disputes concerning a third-party claim. It should be added that since enactment of the Medicare, Medicaid and SCHIP Extension Act, see 42 U.S.C. § 2495y(b), certain insurers and defendants are subject to reporting requirements regarding settlements to ensure that that government payors are appropriately reimbursed for medical expenditures. See id. These procedural considerations provide ample incentive for plaintiffs' lawyers to determine immediately whether any third-party claims may exist.

More fundamentally, the existence of third-party claims can impact whether a case is filed in the first place. Consider the following hypothetical to illustrate the point. Suppose that a tort victim suffered \$180,000 in medical expenses and no other compensable injuries as a result of a car accident. Pennsylvania's Department of Public Welfare has paid \$180,000 in Medical Assistance (supported by Medicaid funds) toward the victim's past medical care. Under Pennsylvania law, the Department is entitled to reimbursement against a resulting settlement. See 62 Pa.C.S. § 1409(b). However, the Department generally must reduce its reimbursement claim by a proportionate share of the plaintiff's attorneys' fees and costs. See 62 Pa.C.S. § 1409(b)(7). Further, if the plaintiff were to recover exactly \$180,000 in litigation, the Department would be required to limit its

reimbursement claim to one-half of the recovery after deducting its proportionate share of attorneys' fees and costs. See 62 Pa.C.S. § 1409(b)(11).

Thus, assuming no costs and a one-third contingency fee agreement:

- The Department would receive \$40,000 (\$60,000, or one-third of the \$180,000 settlement, reduced further by one-third for the proportionate payment of fees and costs).
- The plaintiff would receive \$80,000 (\$120,000 minus the Department's share).
- The plaintiff's counsel would receive \$60,000 (one-third of the settlement based on the fee agreement).

Against those expectations, the plaintiff might reasonably conclude that the case was worth pursuing: she could reap \$80,000 from the case even taking into account the Department's prior payments on the plaintiff's behalf. Likewise, plaintiff's counsel might be interested in pursuing the case because her fee may be fully paid notwithstanding the Department's prior payments. This arrangement incentivizes both plaintiff and counsel to move forward with a meritorious case. This heightens the likelihood that the Department will obtain at least partial reimbursement for its Medical Assistance payments.

Let us now change the scenario. Suppose that the Department were entitled to 100% reimbursement of ment that Petitioner advocates here. Now the economic incentive to bring suit is eviscerated. Even if Plaintiff could recover the full \$180,000 of her damages, every penny of that recovery would be paid to the Department. The plaintiff would receive nothing. The plaintiff's counsel would receive nothing. Neither plaintiff nor her counsel has any reason to move forward in those circumstances, and the meritorious case will not be pursued. Regrettably, the Department will receive nothing as a result – a bad deal as compared to the \$40,000 the Department would receive under the first scenario.

These convenient illustrations highlight a reality of tort practice: plaintiffs and their counsel decide to pursue (or not pursue) litigation based on expected outcomes. By reducing the likelihood that plaintiffs or their counsel will benefit from litigation, Petitioner's 100% reimbursement rule will cause meritorious cases to be abandoned. This result harms more than the plaintiffs. It also harms the third party that otherwise would receive reimbursement from a settlement fund. This is the supreme irony of Petitioner's position: in seeking full reimbursement without compromise, Petitioner undermines the likelihood that third-party plans will obtain any reimbursement in some cases. The plans would get nothing at all because their position rendered the suit economically unviable.

II. An equitable approach also promotes settlement without trial.

Not only does Petitioner's approach undermine the incentive for plaintiffs and counsel to pursue meritorious cases (with deleterious effects for thirdparty payors), it also pressures plaintiffs to try cases that otherwise might settle, imposing risks and burdens across stakeholders in the litigation system.

We can illustrate this through a revised scenario. Suppose that a tort case has a fair settlement value of \$100,000. At trial, there is a 25% chance of a \$400,000 jury award in plaintiff's favor but a 75% chance of a defense verdict. A third-party payor has paid \$100,000 for the plaintiff's past medical care.

If the third-party payor must be reimbursed for every penny of the \$100,000 it spent on plaintiff's medical care, there is no incentive for plaintiff to resolve the case for the fair value of \$100,000. This is because neither plaintiff nor counsel would receive money from the settlement; everything would go to the third party. The plaintiff instead is incentivized to try the case. At trial, the plaintiff has a 25% chance of a \$400,000 award. If successful, and assuming a onethird contingency fee and \$10,000 in case costs, the plaintiff would retain approximately \$156,667 after paying attorneys' fees and costs and after reimbursing the third party on its \$100,000 claim. While the outcome of trial is uncertain, a 25% chance at something represents a better option than the 100% certainty of a "fair" settlement that leaves the plaintiff

with nothing and requires her counsel to work for free. Of course, if the plaintiff loses at trial, the third party will obtain nothing.

One can adjust the numbers so they produce more subtle results, but the fundamental point remains: Petitioner's 100% approach imposes burdens that make settlement harder to achieve and heighten the risk of trial. These burdens would affect not only the plaintiff and her counsel. They would weigh on defendants and their liability insurers, who may have wanted settlement and now must incur the cost of trial and the risk of a sizable verdict in plaintiff's favor. They would weigh on the court system, which must devote judicial resources to managing the trial and resulting appeals. These burdens also would weigh on citizens who must serve as jurors, with all the resulting disruption in their lives, all because a third party did not equitably compromise its reimbursement claim.

These are not theoretical concerns. The existence, size, and negotiability of a third-party claim are vital considerations in whether a case is settled or tried. As such, Petitioner's "no compromise" stance does not promote stability and settlement. It does quite the opposite, with burdensome effects on parties, liability insurers, judges, and jurors. Petitioner's argument should be rejected for this reason as well.

III. Negotiation reduces the likelihood of postsettlement disputes.

Petitioner and supporting amici argue that a rule of equity will promote litigation and controversy, while a fixed rule of 100% repayment will promote stability and order. This position is oddly divorced from the day-to-day realities of tort litigation. Plaintiffs' lawyers in Pennsylvania routinely file cases involving tort victims who have received medical care through such third-party payors as Medicare and the Department of Public Welfare. Those third-party claims are commonly negotiated and resolved in the ordinary course of business. They are successfully negotiated every day.

Occasionally, conflict arises about the scope of the third-party's reimbursement rights. See, e.g., McKinney ex rel. Gage v. Philadelphia Housing Authority, No. 07-4432, 2010 WL 3364400 (E.D. Pa. Aug. 24, 2010) (analyzing reimbursement rights under Arkansas Department of Health and Human Services v. Ahlborn, 547 U.S. 268 (2006)); E.D.B. ex rel. D.B. v. Clair, 987 A.2d 681 (Pa. 2009) (analyzing reimbursement rights of the Pennsylvania Department of Public Welfare regarding Medical Assistance payments where the parental claim for minors' medical expenses is time-barred). These occasional disputes refine the legal and equitable relationship between stakeholders and clarify expectations about the outcome of a given dispute. In doing so, they promote and hasten claims resolution in downstream cases. That will happen here if the Court affirms the Third Circuit's decision.

The parties will know the equity matters and adjust expectations accordingly. (It is not complicated to reduce a claim by a proportionate share of attorneys' fees and costs, for example.) The result will not be more litigation, but faster claims resolution.

Negotiation is a useful and effective tool for resolving ligation across the entire spectrum of stakeholders in a tort claim. Negotiation promotes the stable and controlled resolution of claims. It promotes the efficient and decent management of complex litigation. Petitioner decries negotiation as if the sky would fall if lawyers had to talk to one another. If the day-to-day reality of tort litigation is any measure, quite the opposite is true.

It should be emphasized that Petitioner's 100% reimbursement rule may not end tension with plaintiffs over the scope of third-party reimbursement. It instead may focus attention on other issues, such as the valid size of the third-party's claim. Sometimes a third party seeks reimbursement for a cost that is factually unrelated to the plaintiff's injury caused by the subject tort, or that would have been paid regardless of the tortious conduct. A plaintiff may contest such a charge as not properly reimbursable. Alternatively, perhaps the third party did not actually pay the amounts listed on the statement of claim, but paid some lesser amount, and only the lesser amount should be reimbursed.

These prosaic conflicts become more likely if third parties must be reimbursed to the exact tune of their claim, as plaintiffs are incentivized to find other means for reducing claims when equity has no place at the table.

Petitioner's 100% reimbursement rule may not actually reduce tension with third-party payors. It may only change the points in contention. Surely it would be preferable to do what Section 502(a)(3) seems explicitly to contemplate: applying basic fairness when evaluating third-party reimbursement, for the benefit of all stakeholders to a tort settlement — not just for plaintiffs and their counsel, but also for defendants, liability insurers, judges, juries, and the judicial system as a whole.

CONCLUSION

The judgment of the United States Court of Appeals for the Third Circuit should be affirmed.

Respectfully submitted,

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AMICUS CURIAE BRIEF

BRIEFS

IN THE

Supreme Court of the United States

US AIRWAYS, INC., IN ITS CAPACITY AS FIDUCIARY AND PLAN ADMINISTRATOR OF THE US AIRWAYS, INC. EMPLOYEE BENEFITS PLAN. Petitioner.

JAMES E. MCCUTCHEN, et al., Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF AMICI CURIAE UNITED POLICYHOLDERS, THE ARIZONA ASSOCIATION FOR JUSTICE, THE UTAH ASSOCIATION FOR JUSTICE, THE SAN FRANCISCO TRIAL LAWYERS ASSOCIATION. THE MINNESOTA ASSOCIATION FOR JUSTICE, THE SOUTH DAKOTA TRIAL LAWYERS ASSOCIATION, THE NEW JERSEY ASSOCIATION FOR JUSTICE AND THE NEW YORK STATE TRIAL LAWYERS ASSOCIATION IN SUPPORT OF RESPONDENTS

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BRIEF OF AMICI CURIAE UNITED
POLICYHOLDERS, THE ARIZONA ASSOCIATION
FOR JUSTICE, THE UTAH ASSOCIATION FOR
JUSTICE, THE SAN FRANCISCO TRIAL
LAWYERS ASSOCIATION, THE MINNESOTA
ASSOCIATION FOR JUSTICE, THE SOUTH
DAKOTA TRIAL LAWYERS ASSOCIATION, THE
NEW JERSEY ASSOCIATION FOR JUSTICE AND
THE NEW YORK STATE TRIAL LAWYERS
ASSOCIATION IN SUPPORT OF RESPONDENTS

INTERESTS OF AMICI CURIAE

United Policyholders ("UP") is a non-profit 501(c)(3) organization founded in 1991 that serves as a voice and an information resource for insurance consumers in all 50 states. As part of its mission, UP is concerned about the implementation and application of laws and rules under the Employee Retirement Income and Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq., because a substantial percentage of the insurance market is governed by ERISA.

UP's work is divided into three program areas: Roadmap to Recovery (claim assistance), Roadmap to

¹ Pursuant to Supreme Court Rule 37.6, amici curiae state that no person or entity other than the amici curiae, and their undersigned counsel made a monetary contribution to the preparation or submission of this brief. No attorney for any party authored this brief in whole or in part. The parties' letters consenting to the filing of this brief have been filed with the Clerk's office in accordance with Supreme Court Rule 37.3(a).

Preparedness (promoting insurance/financial literacy) and Advocacy and Action (advancing the interests of insurance consumers in courts of law, before regulators and legislators, and in the media). Donations, foundation grants and volunteer labor support the organization's work. UP does not accept funding from insurance companies.

Advancing the interests of policyholders through participation as amicus curiae in insurancerelated cases throughout the country is an important part of UP's work. UP's reputation as a reliable friend of the court was enhanced when its amicus curiae brief was cited in this Court's opinion in Humana v. Forsyth, 525 U.S. 299 (1999), and its arguments were adopted by the Texas Supreme Court in Excess Underwriters at Lloyd's, London, et al. v. Frank's Casing Crew & Rental Tools Inc., 2008 Tex. LEXIS 92, 51 Tex. Sup. J. (Tex. Feb. 1, 2008), as well as by the California Supreme Court in Vandenberg v. Superior Court, 88 Cal. Rptr.2d 366 (Cal. 1999) and numerous other proceedings including TRB Investments, Inc. v. Fireman's Fund Ins. Co., 145 P.3d 472 (Cal. 2006). Other ERISA cases in which UP has been granted leave by the Supreme Court to participate as amicus curiae include: Hardt v. Reliance Standard Life Insurance Co., 130 S. Ct. 2149 (2010); Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008); Aetna Health, Inc. v. Davila, 542 U.S. 200 (2004); and Rush Prudential HMO v. Moran, 536 U.S. 355 (2002). UP also was granted leave to file an amicus brief in Skinner v. Northrop Grumman Retirement Plan B. No. 10-55161 (Doc. 53) (9th Cir. 2012).

We seek to assist the Court in this case because of its potential impact on millions of employees and policyholders enrolled in employee benefit plans governed by ERISA.

The following trial lawyer associations also join in this brief as *amici curiae* in support of Respondents:

The Arizona Association for Justice, formerly known as the Arizona Trial Lawyers Association, is a voluntary association of approximately 700 lawyers dedicated to protecting the rights of their clients and the public to recover fair personal-injury and wrongful-death damages and to obtaining the insurance benefits that their clients and others have paid to receive.

The Utah Association for Justice is a voluntary association of 420 lawyers dedicated to protecting the rights of their clients and the public to recover fair personal injury and wrongful death damages, and to obtaining the insurance benefits that their clients and others have paid to receive.

The San Francisco Trial Lawyers Association is a voluntary association of approximately 932 members dedicated to protecting the rights of their clients and the public to recover fair personal injury and wrongful death damages, and to obtaining the insurance

benefits that their clients and others have paid to receive.

The Minnesota Association for Justice is a voluntary association of 907 lawyers dedicated to protecting the rights of their clients and the public to recover fair personal-injury and wrongful-death damages and to obtaining the insurance benefits that their clients and others have paid to receive.

The South Dakota Trial Lawyers Association ("SDTLA") is a voluntary association of 322 attorneys who, inter alia, represent individual plaintiffs in personal injury cases and other civil actions in South Dakota. Since South Dakota is a small state in terms of population (total population of 814,180 as per the 2010 census), members of SDTLA frequently serve as defense counsel as well as plaintiff's counsel.

The New Jersey Association for Justice is a voluntary association of 2,383 members, of which 2,134 are attorneys, dedicated to protecting the rights of their clients and the public to recover fair personal-injury and wrongful-death damages and to obtaining the insurance benefits that their clients and others have paid to receive.

The New York State Trial Lawyers Association is a voluntary association of 3300 members dedicated to protecting the rights of their clients and the public to recover fair personal injury and wrongful death damages and to obtaining the insurance benefits that their clients and others have paid to receive.

associations and their members have witnessed the devastating effects endured by individuals as a result of ongoing efforts by ERISA insurers and plan sponsors to enforce subrogation and reimbursement provisions since the 1990s. Personal injury cases were widely held to be inappropriate areas in which to afford a subrogation remedy to a health insurer when ERISA was enacted in 1974 and Congress never has authorized subrogation by an ERISA health plan. Thus, these efforts represent a unilateral attempt to create rights for insurers and plan sponsors which did not exist in 1974 and never have been approved by Congress.

SUMMARY OF THE ARGUMENT

Contrary to the assumptions made by Petitioner and its amici, the US Airways, Inc. Health Benefit Plan ("the Plan") is not a negotiated agreement between US Airways, Inc. and its employee, James McCutchen, under which Mr. McCutchen assumed the risk of medical costs from a catastrophic accident caused by a third party. Nor was the Plan an arms-length, negotiated agreement that put Mr. McCutchen on notice that if he recovered damages as the result of an injury caused by another party, he would be required to reimburse the Plan a sum in excess of what he recovered, net of

the attorneys' fees he incurred in prosecuting his third-party suit.

Instead, this Court has recognized that ERISA is the outgrowth of trust law and that courts are to fashion a "federal common law of rights and ERISA-regulated obligations under Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, Thus, as the Third Circuit court 110 (1989). correctly determined, reimbursement claims seeking equitable restitution must be accompanied by a rule that such claims are subject to equitable principles irrespective of contrary plan language. If plan terms are inequitable, unjust, or unconscionable as applied, courts retain the power to modify such terms in order to bring them into alignment with ERISA's purpose, embodied in ERISA § 2(b), 29 U.S.C. § 1001(b), of protecting "the interests of participants in employee benefit plans and their beneficiaries," and its fiduciary goals, expressed in ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1), requiring fiduciaries to act exclusively in the interest of the participants and their beneficiaries. plan's Unsupported assertions about the financial impact of reimbursements on plan rates ignore the realities of how health plans are funded and are an insufficient basis to undermine the language and purposes of ERISA.

ARGUMENT

A. Section 502(a)(3) Of ERISA Does Not Permit
A Fiduciary To Bring A Contract Action For
Legal Relief

1. The Terms Of The Plan Are Unclear

Contrary to the arguments advanced by Petitioner, the Subrogation and Right of Reimbursement Provision of the Plan is not merely a "simple quid pro quo," Brief for Petitioner at 2, strictly enforceable in accordance with its contract terms.

As a threshold matter, Petitioner provided Respondents with information that Mr. McCutchen was a participant in two different plans, at least one of which is funded by insurance. Defendants' Responsive Concise Statement of Material Facts In Opposition to Plaintiff's Motion for Summary Judgment ¶ 2 (JA 36); Affidavit of Jon R. Perry, Esq. ¶ 13 (JA 41). The reimbursement claim in this case originally was asserted by Ingenix Subrogation Services,² an organization retained by United Healthcare Services to pursue reimbursement for medical benefits paid on behalf of Mr. McCutchen under the US Airways Group, Inc. America West Plan # 000704267. See Letter dated June 26, 2007

² In April, 2011, the name of Ingenix, a subsidiary of United HealthGroup, was changed to OptumInsight. Emily Berry, Ingenix name retired as United re-brands subsidiaries, amednews.com (April 24, 2011), available at http://www.ama-assn.org/amednews/2011/04/25/bisd0426.htm.

(JA 42); Letter from Ingenix, dated October 6, 2008 (Dist. Ct. Doc. 35-2 at page 23 of 33 (filed 12/04/2009)). Ingenix asserted that it was seeking recovery on behalf of United Healthcare SELECT Plan for America West Holdings Corporation, under which United Healthcare appeared to pay claims as insurer. (See Dist. Ct. Doc. 35-2 at pages 11, 13-14, 24 of 33 (filed 12/04/2009)).3

In this litigation, however, Petitioner seeks to enforce rights under the US Airways, Inc. Health Benefit Plan. (Dist. Ct. Doc. 30-3 (filed 10/30/2009)). According to the Company's Form 5500, filed to satisfy reporting requirements of both the Department of Labor and the IRS, see http://www.irs.gov/pub/irs-pdf/i5500.pdf, the Plan is funded through the general assets of the company and through insurance.⁴ Thus, under the Plan,

³ Neither a complete plan document nor SPD for this Plan is in the record or was provided to Respondents.

The 2009 form 5500 filed by US Airways for its health plan shows that its funding arrangement on line 9a and its benefit arrangement on line 9b are from insurance, as well as assets of the plan sponsor. A copy of the US Airways Plan form 5500 is accessible on the database maintained by the U.S. Department of Labor, using search criteria seeking 2009 form 5500 for EIN 530218143, and the 3 digit plan number of 501, at http://www.efast.dol.gov/portal/app/disseminate?execution=els 2. Schedule A lists United Healthcare Insurance Company as the insurer referenced in line 9. Schedule C of the form 5500 reveals that in 2009 alone, US Airways paid United Healthcare almost \$11 million. Id. The 2010 form 5500, accessed at the website above, shows similar information, except that in addition to United Healthcare, BlueCross BlueShield of NC is listed as a claims processor. The 2003 SPD for the Plan

insurance may have covered Mr. McCutchen's medical expenses, a typical arrangement for a self-funded plan. See discussion infra Part C.⁵

Thus, even if the Plan covered Mr. McCutchen, insurance likely played a role in paying his medical expenses. The Plan should not be enforced as though it were a contract between a plan sponsor and participant where its terms are either unclear or concealed.

US Airways May Not Bring A Claim For Legal Relief

Even if the Plan were an agreement by which US Airways would advance medical costs to treat injuries caused by a tortfeasor on the condition that Mr. McCutchen would reimburse those costs upon recovery from a third party, it cannot be concluded that Mr. McCutchen agreed to reimburse his employer from the underinsured motorist recovery he received from his own automobile insurer for which he paid separate premiums. Nor can it be concluded that Mr. McCutchen agreed to turn over to the Plan a payment larger than his actual net recovery.

indicates that BlueCross BlueShield, not United Healthcare, is the claims administrator of the Plan, (Dist. Ct. Doc. 30-3 at pages 26, 100 of 110 (filed 10/30/2009)), suggesting that United Healthcare is an insurer.

⁵ Petitioner sought a protective order to avoid producing documents from which Respondent could discern the provisions of the Plan. (See Dist. Ct. Doc. 16 (filed 07/16/2009)).

Undoubtedly, the promise of health benefits is a valuable inducement for individuals to accept employment with companies. However, it is pure speculation to suggest that Mr. McCutchen knowingly and voluntarily entered into the sort of quid pro quo that Petitioners and their amici maintain, by which the Plan benevolently advances the costs to cover catastrophic medical expenses, the risk of which is fully assumed by the beneficiaries. To the contrary, US Airways informed its employees that the goal of the Plan is to:

- Protect you and your family from major financial loss;
- Provide competitive benefits that will attract and retain qualified employees.

(Dist. Ct. Doc. 30-3 at page 2 of 110 (filed 10/30/2009)). Thus, U.S. Airways promised its employees, such as Mr. McCutchen, that as part of the terms and conditions of employment, they would be protected from personal financial loss caused by large medical expenses due either to illness or injury. The Plan does not contemplate that the employee would assume the full risk of loss caused by a third party. Any argument that the reimbursement clause should be enforced as part of a bargained-for exchange therefore rests on a false premise.

Further, as Brief for Petitioner at 5 admits, the employer designs and controls the terms of the plan; without judicial oversight permitting the application of equitable principles to equitable claims for reimbursement, Plan terminology could become unconscionable. If the Plan permitted double reimbursement, such a term would undoubtedly be unenforceable. Yet here Petitioner seeks to enforce a term requiring a plan participant to reimburse a larger sum than the net recovery he received.

While the Plan's reimbursement rights may be enforced through an action seeking "appropriate equitable relief under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), by the terms of the statute such action is exclusively an equitable, not a legal, right. Great-West Life & Annuity Insurance Co., v. Knudson, 534 U.S. 204, 221 (2002). Under analogous trust law principles, a trustee cannot simply enforce a provision of the trust that could cause substantial harm to beneficiaries, but rather is under a duty to modify the provision of the trust. Restatement (Third) of Trusts § 66(2) and cmt. on subsection(2) (2003). Thus, a fiduciary may not blindly enforce the terms of a plan without regard to the consequences to participants and beneficiaries and is limited in doing so by equitable principles.

In any event, Congress authorized only "a participant or beneficiary," but not a fiduciary like US Airways, to bring a contract-like claim to enforce his rights under the terms of the plan under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). Knudson, 534 U.S. at 221. A fiduciary is limited to pursuing "appropriate equitable relief" under § 502(a)(3), but as Knudson holds, that section does not authorize

fiduciaries to seek legal relief, that is, the imposition of personal liability on a participant for a contractual obligation to pay money. Id. By seeking a recovery in excess of the funds actually received by Mr. McCutchen and which may be satisfied only from his personal assets. Petitioner's claim is quintessentially one for legal, not equitable, restitution, and is not authorized by § 502(a)(3). Thus, any argument premised upon the notion that US Airways and Mr. McCutchen entered into a quid pro quo is both legally and factually implausible. Even if there was some element of a quid pro quo, US Airways is limited to seeking equitable relief and therefore may not under any circumstances seek recovery from McCutchen's personal assets in excess of the funds over which US Airways may assert a lien by agreement in accordance with Sereboff v. Mid-Atlantic Medical Services, Inc., 547 U.S. 356, 362-64 (2006). See CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1878-1879 (2011).

B. Any Reimbursement Recovery Will Inure To The Benefit Of United Healthcare Or The Company, Not To The Benefit Of Plan Participants and Beneficiaries

Nor is it correct to assert, as Petitioner maintains, that full reimbursement by Mr. McCutchen is necessary to preserve Plan assets to pay future claims. Brief for Petitioner at 27 et seq. It appears that Mr. McCutchen's medical expenses were covered, at least in part, by United Healthcare pursuant to a policy of insurance. See discussion supra Part A.1. Thus, any reimbursement would

flow to United Healthcare as insurer, and not to the Plan.⁶

Brief for Petitioner at 27 suggests that any amounts recovered are Plan assets. Thus, permitting a reimbursement recovery by US Airways on behalf of United Healthcare poses serious problems under ERISA. As a fiduciary, US Airways must discharge its duties with respect to the Plan "solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries." ERISA § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A). If US Airways is being used to direct reimbursement recoveries to United Healthcare, it stands in violation of the "exclusive benefit" rule of Section 404(a)(1)(A).

Moreover, ERISA § 403(c), 29 U.S.C. § 1103(c) mandates that "assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purpose of providing benefits to participants in the plan and their beneficiaries." The payment of a reimbursement award to United

⁶ It does not appear that United Healthcare's role in the Plan is as a claims administrator of a self-funded Plan, because the record shows that the only "claims administrator" for the Plan during the time in question was BlueCross BlueShield. (Dist. Ct. Doc. 30-3 at pages 26, 100 of 110 (filed 10/30/2009)).

⁷ If the Subrogation and Right of Reimbursement provision relieves US Airways of its fiduciary duty to act for "the exclusive purpose of . . . providing benefits . . ." under ERISA § 404(a)(1)(A), then the provision should be deemed as void as against public policy under ERISA § 410, 29 U.S.C. § 1110.

Healthcare, as a health insurer, could violate ERISA's anti-inurement provision because it diverts assets from the mandated purpose of "providing benefits to participants in the plan and their beneficiaries" and will not be used to "fund" the Plan. Without any showing in this record that the recovery will benefit the Plan and its participants, it appears the money will flow to United Healthcare in violation of ERISA's anti-inurement provision.

Even if the reimbursement payment is received by US Airways, there is nothing in the record from which to conclude that the funds would be used to provide benefits to plan participants and their beneficiaries or to defray future expenses. As noted above, the Plan is funded by insurance and general assets. Thus, any recovery that does not flow to an insurer would be directed to the general assets of US Airways, which has no obligation to continue to fund the Plan, see 2003 SPD for the Plan (Dist. Ct. Doc. 30-3 at page 101 of 110 (filed 10/30/2009)), and could use the funds to benefit the company.8

⁸ It is possible that any recovery will be used to increase the company's or its insurer's executive compensation or shareholder dividends, not to reduce premiums or rates. See Scott M. Aronson, ERISA's Equitable Illusion: The Unjust Justice of Section 502(a)(3), 9 Empl. Rts. & Emply. Pol'y J. 247, 286 (2005). The use of subrogated or reimbursement recoveries to enhance executive compensation and dividends is consistent with reports regarding United Healthcare. See, e.g., Patrick Kennedy, UnitedHealth CEO Stephen Hemsley was paid \$102M in '09, Minneapolis Star Tribune, April 12, 2010; Tom Murphy, Report hints reform offers growth for carriers, (Oct. 2012). available benefitapro 2. at

In addition, a recovery in 2013 for expenses incurred by a participant in 2007 or 2008, when Mr. McCutchen's accident occurred and the expenses were paid, would at best lessen only the Company's share of a predetermined contribution made on an actuarial basis for 2013. The employee's contribution is determined "prior to the beginning of each Plan Year (the 12-month period, beginning each January 1, used by the Plan to conduct its finances), based on an evaluation of expected medical and dental administrative and claim expenses for the upcoming year." 2003 SPD for the Plan (Dist. Ct. Doc. 30-3 at page 16 of 110 (filed 10/30/2009)). According to the SPD, the employee's contribution is based on expected expenses and does not take into account potential reimbursements. Thus, it is sheer speculation to conclude that a reimbursement recovery is used to defray employee contributions for future years.

It is important to remember that when ERISA was enacted in 1974, subrogation remedies were generally not afforded to health insurers in personal injury cases. See Brendan S. Maher & Radha A. Pathak, Understanding and Problematizing Contractual Tort Subrogation, 40 Loy. U. Chi. L. J. 49, 66 et seq. (2008). The first reported judicial decision involving an effort by a health insurer to seek subrogation or reimbursement from the

http://www.benefitspro.com/2012/10/02/ report-hints-reform-offers-growth-for-carriers (reporting that United Healthcare expects higher earnings per share than previous forecasts).

proceeds of a personal injury recovery is Frost v. Porter Leasing Corp., 436 N.E.2d 387 (Mass. 1982), in which the court flatly rejected an insurer's claim of implied subrogation. This Court has been careful to protect pre-ERISA rights enjoyed by employees and beneficiaries. Firestone, 489 U.S. at 113-14 ("Adopting Firestone's reading of ERISA would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted.").

The result urged by Petitioner could confer on insurers that provide coverage in the context of so-called self-funded plans greater rights than they enjoy outside of ERISA. The Court should not adopt a rule in this case that eliminates protections from subrogation and reimbursement claims that employees and their beneficiaries enjoyed before ERISA was enacted.

C. The Plan Does Not Allocate To Participants The Risk Of Catastrophic Medical Costs Caused By A Third Party

The record is devoid of evidence suggesting that Mr. McCutchen understood he was assuming the risk of the medical costs he incurred when he was injured, which costs the Plan, in its benevolence, covered with the expectation that he would repay.⁹

⁹ The Plan is not necessarily the first in line to pay medical expenses caused by an accident. For example, automobile insurers in Pennsylvania must pay at least the first \$5000 of first party medical expenses. See, e.g., 75 Pa. C. S. §§ 1711.

If he considered such a risk at all, the fact that he purchased underinsured motorist coverage suggests that he sought to protect himself against such risk.

Rather, the information distributed by US Airways to its employees, quoted supra page 10, indicates that US Airways assumed the risk of catastrophic loss. Further, US Airways had the ability to shift that risk to an insurer like United Healthcare, and did so. Thus, there is no basis to conclude that limiting reimbursement will threaten the solvency of the Plan.

The Second Amendment to US Airways, Inc. Health Benefit Plan (January 1, 1982 Restatement), adopted on December 30, 1998, replaced section 6.1 of the Plan to provide:

Benefits under the Plan shall be paid from the general assets of the Employer, provided through a group contract with an insurance carrier or health maintenance organization as determined by the Company and/or provided а trust established bv Employer.... In the event any benefit is to be provided, in whole or in part, through a group contract with one or more insurance companies and/or health maintenance organizations, the Employer shall remit to insurance companies and/or health such

The Plan also does not cover medical expenses covered by workers' compensation insurance. (See (Dist. Ct. Doc. 35-2 at page 24 of 33 (filed 12/04/2009)).

maintenance organizations as premium payments its contributions and any Participant contributions in respect of such benefits, as appropriate.¹⁰

Employees contribute to the cost of coverage. (Dist. Ct. Doc. 30-3 at page 16 of 110 (filed 10/30/2009)).

Even if the Plan is "self-funded," Pet. App. 22a, or "self-financed," Pet. App. 3a (a fact that is not clear from the record), that is not to say that US Airways is "self-insured" such that it pays all claims under the Plan. "Self-funded" is not the same as "self-insured." An entity that "self-insures" retains the insured risks without any risk transfer to a commercial insurer. Robert E. Keeton & Alan I. Widiss, Insurance Law: A Guide to Fundamental Principles, Legal Doctrines, and Commercial Practices (Hornbook Series), §§ 1.2, 1.3(b) (1988).

In contrast, under a self-funded benefit plan, an employer assumes the risk of providing health insurance to its employees, instead of ceding the risk to a third-party insurance company. The employer

¹⁰ The plan document is not in the record of this case because it was never provided to Mr. McCutchen or his counsel, despite their repeated requests for it while this case was pending in the district court. See notes 3, 5 supra. We have been advised that Respondents only received the plan document recently, after the Court granted the petition, after it was requested by the Solicitor General. Because it is the relevant document, we cite it here.

then either sets aside funds for its employees' covered medical expenses or pays for such expenses out of its general accounts. *Texas Dept. of Ins. v. Am. Nat. Ins. Co.*, 10-0374, 2012 WL 1759457 *1 (Tex. May 18, 2012), *reh'g denied* (Aug. 31, 2012).

However, a self-funded ERISA health plan may allocate risk by blending "self-insured" coverage, that is, payment of claims from its own assets, with "insured" coverage, paid by an insurer, which apparently is what happened in this case with the group policy issued by United Healthcare. See supra Part A.1. A self-funded health plan also may purchase "reinsurance" or "stop-loss" insurance as a way to protect the employer's corporate assets against the risk of catastrophic claims. 11 Self-funded

¹¹ There are two types of stop loss insurance that are typically available for a self-funded plan: (1) specific stop-loss, which protects against a high claim from an individual, and (2) aggregate stop-loss, which puts a ceiling on the amount of expenses the employer pays during the contract period and where the employer is reimbursed at the end of the contract for aggregate claims. Texas Dept. of Ins. v. Am. Nat. Ins. Co., 2012 WL 1759457 *3. See also Jonathan Edelheit & Daniel Pyne. The Benefits and Flexibility of Self-Funded Insurance, SELF FUNDING MAGAZINE (Aug. 2012). available 2. http://www.selffundingmagazine.com/article/the-benefits-andflexibility-of-self-funded-insurance.html (cited in BCBS Amicus Br. at 4 n.5) (recommending that risk of catastrophic claims handled through stop loss insurance, without mention of subrogation or reimbursement). The dollar amount above which the employer is covered by the stop loss, and therefore not at risk, is called the attachment point. Katheryn Linehan, Self-insurance and the Potential Effects of Health Reform on the Small-Group Market, National Health Policy Forum (Dec. 2012). available at http://www.nhpf.org/library/ 20. details.cfm/2839 (cited in BCBS/Rawlings Amicus Brief at 16

plans typically hire third parties to administer the plan and often purchase stop-loss insurance to limit financial exposure to catastrophic losses. 12 Section 6.1 of the Plan clearly contemplates a role for insurance.

Thus, a Plan may be self-funded and still use insurance to limit its risk of loss. Such arrangement is beneficial to the stop-loss insurer, which thus may be permitted to evade state law regulating insurance. As discussed in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), ERISA's "deemer" clause permitted a self-funded plan to evade Pennsylvania law. However, as to insured plans, this Court explained:

[E]mployee benefit plans that are insured are subject to indirect state regulation. An insurance company that insures a plan remains an insurer for purposes of state laws, "purporting to regulate insurance" after application of the deemer clause [of ERISA]. The insurance company is therefore not

note 13) (discusses mechanisms for shifting risk, but does not mention anything about relevance of reimbursement or subrogation in determining cost and risk). In *Knudson*, it was the stop loss insurer that paid for the loss above the first \$75,000 seeking reimbursement against the plan participant. See Knudson, 534 U.S. at 207.

¹² A self-funded plan may use a commercial insurer, called a "claims administrator" or "third party administrator" ("TPA") to handle "claims." According to the SPD for the Plan, BlueCross BlueShield acted as the administrator of the Plan. (Dist. Ct. Doc. 30-3 at pages 26, 100 of 110 (filed 10/30/2009)).

relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

Id. at 62.

A reimbursement recovery that flowed to United Healthcare, as insurer, would, by application of ERISA's "saving clause," violate Pennsylvania law prohibiting insurers from obtaining recovery from an insured's tort recovery and enable United Healthcare to disregard Pennsylvania's subrogation law. This Court should not countenance United Healthcare's apparent attempt to circumvent Pennsylvania's prohibition against subrogation and reimbursement by bringing this action in the name of the Plan administrator even though the record shows it seeks reimbursement on its own account. rather than on account of the Plan.

This issue is not unique to the Plan. The fact that self-funded plans are governed by ERISA, which preempts state law, see FMC Corp., 498 U.S. at 61, provides an advantage to an employer that self-funds, as opposed to one that fully insures its health plan. Self-funded plans can and do mitigate risk by relying on stop-loss coverage, but they are not subject to the same level of state regulation as fully-insured plans. See Texas Dept. of Ins. v. Am. Nat. Ins. Co., 2012 WL 1759457 * 4; Christine Eibner et al., Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and

Education Reconciliation Act of 2010 (ACA), RAND Health (2011), p. 21, available at http://www.rand. org/pubs/technical_reports/TR971.html (cited in Blue Cross Blue Shield Assoc., et al. Amicus Br. (hereinafter "BCBS Amicus Br.,") at 16 n. 3); Joanne Wojcik, Reform Law Could Fuel Self Funding (Feb. 2012). available at http://www. 19. businessinsurance.com/article/20120219/NEWS05/30 2199999?tags=|74|278|305|339|342, in BCBS Amicus Br. at 4 n. 4 (other advantages are that self-funded benefit plans are not subject to state benefit mandates or the same premium taxes as fully insured plans). Employers can determine exactly how much risk to assume, and can purchase stop-loss coverage to assume the risk above the chosen attachment point.

In short, the Court should not permit a reimbursement recovery that flows to the benefit of an insurer, contrary to ERISA's protections of the interests of participants and beneficiaries, and that evades "saved" state insurance law.

It is unclear how insurance purchased from United Healthcare was used in this case. However, any suggestion that a self-funded plan is unable to protect itself against catastrophic losses, unless it is entitled to full reimbursement from beneficiaries' third party recoveries, regardless of the beneficiaries' net recovery or the fees and costs incurred, ignores the reality that self-funded plans can and do protect themselves through their own purchase of insurance. Further, information available in this case indicates that the US Airways

shifted some or all of the risk of catastrophic loss to United Healthcare. See supra Part A.1.

Typically, so called self-funded plans are able rationally to allocate the risk of catastrophic loss. US Airways did so in this case. Thus, applying equitable limitations on reimbursement claims will not threaten the solvency of plans that have purchased insurance to protect them from such losses.

- D. Affirmance Of The Third Circuit's Opinion Will Not Weaken Or Otherwise Affect The Solvency Of Employer-Sponsored Health Plans
 - 1. Equitable Limitations On Rights Of Reimbursement Will Not Affect Rates For Self-Funded Plans

There is no support in either the record or which may be derived from empirical studies for the speculative arguments made by Petitioner and its amici that any limitations on reimbursements from third party recoveries by employer sponsored health plans, whether self-funded or insured, will cause premium rates to skyrocket or will threaten plans' solvency. Indeed, there is no such evidence whatsoever.

In the case of insured plans, the setting of insurances rates for the transfer of the risk from the insured to the insurer encompasses the insured's prorata share of the total estimated losses for the pool,

as well as the insured's pro rata share of the costs. expenses and profit margin to be borne by the insurer for setting up and administering the insurance undertaking. Keeton & Widiss, supra, § 1.3(b)(2)(1988). The prospect of a successful recovery from a third party, which is conjectural and remote in nature, is not utilized as a factor in the insurer's rate determination. See, e.g., Aronson, supra note 8, at 285; Edwin W. Patterson, Essentials of Insurance Law § 33, at 151-52 (2d ed. 1957); John F. Dobbyn, Insurance Law in a Nutshell 384 (4th ed. West Many states prohibit reimbursement or subrogation recoveries since insurers have already been paid a premium to cover the loss, regardless of its cause. See, e.g., Allstate Ins. Co. v. Druke, 576 P.2d 489, 492 (Ariz. 1978); Maxwell v. Allstate Ins. Co., 728 P.2d 812, 815 (Nev. 1986); Travelers Indem. Co. v. Chumbley, 394 S.W. 2d 418, 425 (Mo. App. 1965); DeCespedes v. Prudence Mut. Cas. Co., 193 So. 2d 224, 227-28 (Fla. Dist. Ct. App. 1966).13

There is no basis to conclude that ratemaking for self-funded plans is any different, as argued by Petitioner's *amici.*¹⁴ There have been no valid industry-wide studies performed or empirical data

¹³ The role of subrogation and reimbursement in rate making is discussed at length in Roger M. Baron, Subrogation: A Pandora's Box Awaiting Closure, 41 SD L. Rev. 237, 243-245 (1996).

¹⁴ For example, Gary L. Wickert, The Societal Benefits of Subrogation, available at http://www.mwl·law.com/CM/Resources/The Societal Benefits of Subrogation.pdf, cited in BCBS Amicus Br. at 21, contains no citations.

assembled that demonstrate the impact of subrogation recoveries on health plan rates. Holly Ludwig, Restoring Sanity to Subrogation After Sereboff, 9 Nev. L.J. 431, 450 (2009). The studies cited by amici describe the rise in cost of employer-sponsored coverage, but there is neither any mention nor suggestion that there is a link between reimbursement and subrogation and the costs or solvency of health plans. 16

¹⁵ As discussed in Christine Eibner et al., supra p. 21-22 (cited in BCBS Amicus Br. at 16 n. 3), there is generally a lack of reliable data on premiums for self-funded plans, a lack of information concerning use of stop-loss policies and an absence of data linking employees, employers and health expenditures.

¹⁶ While the cost of employer-sponsored coverage is increasing. limits on reimbursement is never cited as the reason for the rise in costs. See, e.g., The Henry J. Kaiser Family Foundation & Health Research & Education Trust, Summary of Findings, Employer Health Benefits 2011 Annual Survey (2011). available at http://ehbs.kff.org/pdf/2011/8225.pdf (cited in Chamber of Commerce of the United States of Am., et al. Amicus Brief at 18-19 n. 2; BCBS Amicus Br. at 3, 16). In fact, that organization's 2012 report shows that at large firms (200 or more workers), the average family premium for covered workers in firms that are fully insured has grown at a similar rate to premiums for workers in fully or partially self-funded firms from 2007 to 2012. The Kaiser Family Foundation and the Health Research & Educational Trust, Employer Health 2012 Annual Survey (2012)http://ehbs.kff.org/pdf/2012/8345.pdf. Since, as discussed in the next section, state laws often limit or prohibit subrogation by health insurers, this statistic suggests that the rise in rates is due to some other factor than the plans' ability to recoup costs from third parties. Chad Terhume, About 10% of Employers To Drop Health Benefits, Study Finds, L.A. Times (July 24, 2012) (cited in BCBS Amicus Br. at 3 n. 2) states that employers

Thus, the Court is left without grounds to conclude that limiting reimbursement in this case will somehow lead to increased rates paid by other employees or trigger plan insolvency.

2. Consideration Of Reimbursement And Subrogation In Setting Rates Would Have To Consider The Historical Limitations

Despite suggestions to the contrary, the right to subrogation or reimbursement by health insurer from personal injury recoveries historically has been limited or banned altogether. See Johnny C. Parker, The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation, 70 Mo. L. Rev. 723, 737 et seg. (2005) (setting out a state-by-state approach). As noted in Part B above, the first reported judicial decision involving an effort by a health insurer to seek subrogation on a personal injury claim is Frost, supra, which denied the insurer's claim of implied subrogation. Some states, such as Arizona and Missouri, never permitted subrogation on personal injury claims. Chumbley, supra; State Farm Fire & Casualty Co. v. Knapp, 484 P.2d 180 (Ariz. 1971). Other states, such as Oklahoma, Pennsylvania and Nevada, either judicially or legislatively have rejected subrogation and/or reimbursement of medical expense claims. See 36 Okla. Stat. Ann. § 6092 (West 1990); 75 Pa.

attribute increased medical costs to hospitals, inefficiencies and unhealthy lifestyles, not lack of reimbursement or subrogation.

Cons. Stat. Ann. § 1720 (Supp. 1995); Maxwell, supra. Others have applied other limitations. 17

Since the subrogation and reimbursement rights of health insurers historically have been limited, health plans have no basis for arguing that they set rates based on experience regarding expected subrogation and reimbursement recoveries.

There is also no legitimate expectation, based on experience, to full reimbursement in all cases. In fact, Petitioner's *amici* admit that plans generally receive less than full reimbursement for medical costs paid:

plans can—and usually do—work out a mutually beneficial resolution with the participant. It is extraordinarily rare—indeed, in amici's experience, virtually unprecedented—that a participant is ever called upon to reimburse the plan's equitable lien from his own assets.

BCBS Amicus Br. at 5-6. See also Nat'l Coordinating Comm. for Multiemployer Plans

In Elaine M. Rinaldi, Apportionment of Recovery Between Insured and Insurer in a Subrogation Case, 29 Tort & Ins. L. J. 803, nn. 19-46 and accompanying text (1994), the author reports that based on this Court's decision in American Society Co. v. Westinghouse Electric Manufacturing Co., 296 U.S. 133 (1935), a majority of jurisdictions, apply an "insured-whole rule," that is, that the insured must be fully compensated for any uninsured loss before the insurer may share in the proceeds of a recovery from the tortfeasor.

Amicus Br. at 23 (as a practical matter, trustees often agree to reduce a plan's equitable lien against a participant's third party recovery). However, employers and plans cannot always be trusted to apply equitable principles on their own. 18

In view of the legal and practical limitations on reimbursement, health plan cannot possibly set rates based on the expectation or experience of full reimbursement from their participants' third party recoveries. In fact, as revealed by Petitioner's amici, the norm is that in situations where the medical expenses exceed the participant's recovery, the parties agree on a resolution that does not require injured participants to reimburse plans from their own assets. Petitioner simply is trying to use the preemptive scope of ERISA to expand rights of reimbursement and subrogation that it never had and to squeeze from Mr. McCutchen more than what it is entitled to recover under state law. The opinion of the Third Circuit below simply sends the parties back to work out a sensible solution, in keeping with practices well-recognized longstanding and principles of equity, and should be affirmed.

¹⁸ It was only after its victory in the Court of Appeals in Administrative Committee of Wal-Mart Stores v. Shank, 500 F.3d 834 (8th Cir. 2007), cert. denied, 552 U.S. 1275 (2008), which became a public relations nightmare for the retail giant, Wal-Mart decided to let the victim keep the proceeds of her third party recovery. See Randy Kaye, Wal-Mart Brain-damaged former employee can keep money (April 2, 2008) available at http://articles.cnn.com/2008-04-02/us/walmart.decision_1_wal-mart-retail-giant-health-care-plan?_s=PM:US.

3. Rates Are Likely To Be Impacted More By The PPACA Than The Decision In This Case

As noted above, there are no data to support the proposition that reimbursement rights affect the costs of providing employer sponsored health benefits or that affirming the opinion of the Third Circuit will impact the costs of the Plan. What is much more likely to impact the cost of the Plan and achieve significant cost savings ia implementation of the Patient Protection Affordable Care Act ("PPACA"), Pub. L. No. 111-148. 124 Stat. 119 (2010), the constitutionality of which was upheld by this Court in National Federation of Independent Business v. Sebelius, 132 S. Ct. 2566 (2012). PPACA § 1511, 29 U.S.C. § 218a, and PPACA § 1513, 26 U.S.C. § 4980H. employers to enroll employees in an employersponsored health plan or pay an assessment. See also EBSA, DOL, Tech. Rel. 2012-01 (Feb. 9, 2012) http://www.dol.gov/ebsa/pdf/tr12-01.pdf.

Thus, employers may decide whether to offer health coverage or pay the assessment. The cost of coverage likely will be impacted by PPACA's 80/20 Medical Loss Ratio (MLR) rule, requiring health insurers that spend less than 80% of premiums on medical care and quality (or less than 85% in the large group market) to rebate the portion of premium dollars that exceed this limit. HHS, HealthCare.gov available at http://www.healthcare.gov/law/resources/reports/mlr-rebates06212012a. html.

The PPACA mandates requiring employers to provide insurance or to pay assessments will dictate to employers the costs of employer-sponsored health coverage and the type of coverage offered to their employees in the near future. Given the mandates under the PPACA, there seems little long-term relevance to whether health plans may seek reimbursement from a beneficiary's third party recovery to keep down the costs of health coverage.

While the cost of employer sponsored coverage has increased over the years, see The Henry J. Kaiser Family Foundation, The Uninsured: A Primer: Key Facts About Americans Without Health Insurance, at 16-18 (Oct. 2011) (cited in Nat'l Assoc. of Subrogation Professionals, et al. Amicus Br. at 29), that study does not mention or even suggest that limits on reimbursement are responsible for the high cost, which is, in any event, addressed by the PPACA.

E. Limiting Plans To "Appropriate Equitable Relief" Will Not Generate More ERISA Litigation

Petitioner and its amici raise the specter of increased litigation as a last ditch effort to defeat

¹⁹ Insurers will undoubtedly benefit from the mandate, which will direct millions of new customers and their premium dollars to health insurers. See Murphy, supra note 8 (citing estimate that 12 million people will find coverage on insurance exchanges in 2014 and pay a total of \$55 billion in premiums).

any equitable limitations on the rights of self-funded plans to reimbursement. This Court has previously recognized that the threat of increased litigation is insufficient to outweigh the proper application of the statute as written by Congress. See Firestone, 489 U.S. at 114-115.

Moreover, as noted above, plans generally work out a mutually beneficial resolution with the participant. Hence, there is no reason to believe that limiting plans to "appropriate equitable relief" with corresponding consideration of equitable principles will disturb the status quo or preclude a continuation of sensible resolutions of reimbursement claims.

As for the need for uniformity, there cannot be perfect uniformity because the language of plans varies widely and "such disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 381 (2002) (quoting Metropolitan Life Insurance Co. Massachusetts, 471 U.S. 724, 747 (1985)). In fact, one reason an employer may want to adopt a selffunded health plan is to tailor the plan to the needs of its own workforce. See authorities cited supra note 11. Thus, permitting trial courts to continue exercising their traditional role of tailoring the outcome to the specific facts of the situation presented is far more beneficial than applying a mechanical rule that results in the type of public outcry that Shank unfairness and engendered. See supra note 18.

An unfounded threat of increased litigation should not defeat the application of equitable principles in accordance with the very purpose of ERISA.

CONCLUSION

For the foregoing reasons, the decision of the Third Circuit should be affirmed.

Respectfully submitted,

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